Implementing Modified Interaction Guidance as a Treatment for Disrupted Parental Communication in Prince George: A Case Study

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Abstract

Disorganized attachment in infants is the absence or temporary breakdown of an organized strategy to deal with stressful events such as separations, illness, and strange events (Main & Solomon, 1986). Main and Solomon have suggested that infants with disorganized attachment are frightened by their primary caregivers and exhibit behaviours that are disorganized and disoriented (e.g., freezing and head banging). It has been proposed that parents' affective communication errors, such as laughing when the infant cries produce disorganized attachment. Modified Interaction Guidance (MIG; Benoit, Madigan, Leece, Shea, & Goldberg, 2001) is designed to promote sensitive responsiveness and minimize affective communication errors displayed by the caregiver when interacting with the infant. The purpose of the present study was to document the therapeutic and learning processes that occurred when a paraprofessional, who was a non-expert in attachment, conducted MIG with a parent-child dyad under supervision of a psychologist. A goal of this study was to identify and describe key clinician and parent characteristics thought to be related to the therapeutic and learning processes. Results suggest that in this case, a paraprofessional was able to deliver MIG safely with adequate supervision. Several issues in learning and supervisory processes were identified including the need for mechanisms and procedures to ensure client safety and maximize the effectiveness of the clinician's learning process.

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CHAPTER ONE: INTRODUCTION

This thesis used a descriptive exploratory case study research method that captured the processes and challenges experienced by members of a clinical team in Prince George, British Columbia, as they learned and implemented an attachment related clinical intervention, Modified Interaction Guidance (MIG; Benoit, Madigan, Leece, Shea, & Goldberg, 2001). MIG is a clinical treatment used to minimize or eliminate disrupted maternal affective communication displayed when interacting with an infant (Benoit et al., 2001). It has been found that disrupted communication is highly predictive of disorganized attachment in infants (Lyons-Ruth, Bronfman, & Parsons, 1999). Although MIG has been shown to be highly effective when implemented by an expert in attachment (Benoit et al., 2001), the generalizability of MIG to different contexts and settings needed to be evaluated.

The purpose of this study was to document the therapeutic and learning processes that unfolded during MIG sessions and supervision as a paraprofessional, who was a non-expert in attachment, learned to administer MIG. A goal of this study was to identify and describe key clinician and parent characteristics thought to be related to the learning and therapeutic processes involved in MIG. Clinical outcome for the family was evaluated in order to understand the ways in which therapeutic processes of MIG influenced parental behaviour. This thesis was the first step in a larger project documenting the learning and therapeutic processes of MIG with the goal of disseminating this knowledge to other clinical teams wanting to learn and provide MIG to clients.

Literature Review

Disorganized Attachment

From the work of early pioneers in the development of attachment theory, John Bowlby and Mary Ainsworth, the formation of a parent-child attachment bond has long been recognized as an important developmental process in a child's life (Bretherton, 1992). The Ainsworth Strange Situation Procedure (Ainsworth, Blehar, Waters, & Wall, 1978) is one of the earliest procedures developed to observe and classify infant-mother attachment. In the Strange Situation Procedure, the infant is observed in a playroom for a series of eight 3-min episodes in which the mother leaves the infant (either alone or in the presence of a stranger) and rejoins the infant twice. The child's behaviour at reunion with the caregiver is key to scoring attachment status. Ainsworth and colleagues developed three widely known categories of attachment for classifying infants in the Strange Situation Procedure, secure, avoidant, and resistant/ambivalent, which represent organized strategies and behaviours that infants use to cope with stressful situations or regulate emotions. The most adaptive attachment style is considered to be secure attachment. In the Strange Situation, children who are securely attached are able to regulate their distress on separation, make reassuring contact with their mother on her return, and when confident of her responsiveness if she was needed, return to exploring the environment (Ainsworth et al. 1978). A secure attachment relationship provides a child with a sense of security about exploring the world, creates a buffer against the effects of stress and uncertainty, facilitates the regulation of emotions, and serves as a foundation for development of the ability to manage stress

(Ainsworth et al.). A secure attachment relationship establishes the basis on which the child will form healthy relationships with others and interpersonal relationships in the future (Ainsworth et al.). In the Strange Situation, children who are avoidantly attached show physiological signs of distress but show little emotion at separation or reunion (Ainsworth et al.). These children usually turn their attention to the environment instead of their mother as they have learned over time that sensitive care giving is inconsistent or not forthcoming from their mother. In the Strange Situation, children who are resistant/ambivalent become extremely distressed upon separation, are often unable to calm themselves, and become clingy or angry with the mother upon reunion. These three attachment styles are organized strategies that children use for dealing with the stress of separation from their mother.

The development of a new attachment category, disorganized attachment, came about because it became apparent that when reuniting with their parent or caregiver, some children did not display behaviours characteristic of the three organized attachment strategies and were left unclassified in the Strange Situations Procedure. Main and Solomon (1986) reexamined the Strange Situation videotapes for the unclassified infants and noticed that these infants appeared to not have an organized strategy for regulating their emotions and dealing with the stress induced by the Strange Situation Procedure. Instead, upon reunion with their caregiver in the Strange Situation, these infants exhibited bizarre behaviours that tended to be disorganized and/or disoriented (Hesse & Main, 2000; Main & Hesse, 1990; Main & Solomon, 1986). Main and Solomon (1990) identified a number of behavioural indices that reflected disorganized/disoriented behaviour in the presence of the

caregiver. Infants might display contradictory behaviours such as approaching the caregiver but then retreating, misdirected behaviours such as crying after the stranger leaves the room, or stereotypical behaviours such as hair pulling, ear pulling, head banging or other repeated movements illustrate stereotypical concerns. Children may also display behaviours which demonstrate freezing or stilling such as holding a position, gesture, or movement for several seconds, apprehension such as fearful facial expressions or tensing of shoulders when in contact with the parent, and confusion and disorganization such as a hand-to-mouth action or disoriented wandering displayed by an infant upon the return of the parent. The problems experienced by many researchers in classifying infants showing these types of behaviour prompted the emergence of the disorganized/disoriented attachment classification.

Hesse and Main (2000) suggested that instinctually infants approach a parent or caregiver during times of stress, danger, illness, or fatigue and it is primarily the parent's sensitivity and response to the infant's cues that will determine the attachment style that develops. Infants with disorganized attachment differ from infants with other attachment styles in that the infant appears to be frightened by the parent or caregiver (Main & Hesse, 1990). The parent in a disorganized parent-child dyad may exhibit behaviours that are directly frightening to the child such as falling into a trance-like state or physically abusing the child (Main & Hesse, 1990). The parent may appear frightened of the child, displaying behaviours such as backing away from the infant or holding the infant away from self in a rigid manner, which convey fear and confuse the infant (Main & Hesse, 1990). A broad set of maternal

behaviours that include frightened and frightening behaviour and disrupted maternal affective communication have been found more predictive of disorganized/disoriented attachment in infants than frightened or frightening behaviour alone (Lyons-Ruth, Bronfman, & Parsons, 1999; Lyons-Ruth & Jacobvitz, 1999). Lyons-Ruth et al. (1999) proposed that disrupted maternal affective communication was related to fear and disorganization in infants. Disrupted maternal affective communication falls into a number of domains: affective communication errors (e.g., parent laughs when infant cries), role/boundary confusion (e.g., parent seeks reassurance from the infant), fearful/disoriented behaviour (e.g., parent looks at infant fearfully), intrusiveness/negativity (e.g., parent pulls infant by the wrist), and withdrawal (e.g., parent holds infant away from self with stiff arms) (Lyons-Ruth et al., 1999; Lyons-Ruth & Jacobvitz, 1999). Although infants bond with both mother and father, much of the research conducted in the area of disorganized attachment and coding procedures developed for atypical parental behaviour, such as the Atypical Maternal Behaviour Instrument for Assessment and Classification (AMBIANCE; Bronfman, Parsons, & Lyons-Ruth, 2000), have assessed the infant-mother relationship. This gender discrepancy in the research may arise because mothers are often the primary caregivers in infancy. Most attachment theorists assume the findings based on mothers generalize to any primary caregiver (van IJzendoorn, 2005).

Infants with disorganized attachment experience conflict in the face of stressful situations because the parent is both the source of the fright and the source of comfort and resolution (Hesse & Main, 2000; Lyons-Ruth & Jacobvitz, 1999; Main

& Hesse, 1990; van IJzendoorn et al., 1999). Fear provoking behaviours exhibited by the parent activate the child's need to seek proximity and comfort but simultaneously increase the child's fear and distress. This paradox leads to a temporary breakdown of any organized strategy that may exist and results in a display of disorganized/disoriented behaviours by the child. Parental sensitivity and responsivity has been found to be predictive of the three organized attachment strategies (Ainsworth et al., 1978). However, although a significant relationship between parental insensitivity to infants and disorganized attachment has been found to exist, the association is small (van IJzendoorn et al.). Lyons-Ruth and Jacobvitz suggested that most measures of maternal insensitivity or caregiving are not specific enough to detect the maternal affective communication errors that predict disorganized infant attachment.

Prevalence and Stability

A number of studies have examined the prevalence of disorganized infant attachment yielding varying estimates. After conducting a meta-analysis of nearly 80 studies, van IJzendoorn et al. (1999) concluded that the percentage of infants classified as disorganized in middle-class, non-clinical groups in North America was 15%. A significant increase to 25% was found among low-socioeconomic-status groups. In other Western countries, the percentage of infants with disorganized attachment (18%) did not differ significantly from the percentages found in North America. In clinical samples, the percentages of infants with disorganized attachment were higher than the percentages found in non-clinical groups (van IJzendoorn et al.). For instance, among children with neurological abnormalities

(e.g., cerebral palsy, autism, and Down's syndrome) the rate of disorganized attachment was 35%, and among children with mothers with alcohol and drug abuse problems the rate of disorganized attachment climbed to 43%. In their meta-analysis, van IJzendoorn and colleagues also indicated that disorganized infant attachment remains moderately stable over short- and long-term periods (up to 60 months).

Sequelae for the Child

Although theorists argue that disorganized attachment can have long-lasting physiological, psychological, and behavioural implications for a child, all the evidence in the area is correlational and not experimental. Thus findings will be discussed in terms of risk rather than causation. While secure attachment is considered to be a protective factor, disorganized attachment in infancy is considered a risk factor for psychopathology in later childhood and adolescence (Benoit et al., 2001; Carlson, 1998; van IJzendoorn et al., 1999). More specifically, infants with disorganized attachment are often at increased risk for stress management problems, cognitive problems, health problems, externalizing behaviour problems, and dissociative behaviours, all of which can negatively affect the quality of the child's later relationships with others (Carlson).

Researchers have been able to confirm that infants with disorganized attachment have higher levels of cortisol secretion than secure infants (Lyons-Ruth & Jacobvitz, 1999; Spangler & Grossman, 1993). Given that elevated cortisol levels indicate engagement of the stress response, this result suggests that these infants have difficulty managing emotional arousal in stressful situations (Lyons-Ruth &

Jacobvitz). Disorganized attachment in infancy has also been associated with a mild mental lag on the Bayley Scales of Infant Development; however, this association has been found only in low-income settings (Lyons-Ruth & Jacobvitz). Researchers have even found that disorganized infant attachment is associated with feeding problems and failure to thrive (e.g., Coolbear & Benoit, 1999).

Among children who displayed disorganized behaviours as infants, some continue to display the same disorganized behaviours during the pre-school years (Lyons-Ruth & Jacobvitz, 1999). Other children display a role reversal with the parent in which the child acts toward the parent in ways that are more typically displayed by a parent towards a child (Main & Cassidy, 1988). For instance, the child may attempt to control the behaviours of the parent by acting in a punitive manner (e.g., child attempts to embarrass or reject the parent) or caregiving manner (e.g., child is over-protective of parent). The importance of this role-reversal behaviour is that the child falls into a pattern of trying to control others. Some children classified as disorganized during infancy also act aggressively towards their peers by the time they reach preschool (Lyons-Ruth, Alpern, & Repacholi, 1993). As many factors can change in a child's life, the ability to predict hostility and aggression from infancy is difficult and prone to error (Lyons-Ruth et al., 1993). However, looking backward from preschool to infancy, Lyons-Ruth and colleagues concluded that 71% of children who displayed hostile behaviour at age 5 years were classified as disorganized in infancy. Lastly, research has also shown that infants with disorganized attachment may be at heightened risk for the development of altered

states of mind such as absorption or dissociation in childhood and adolescence (Carlson, 1998).

Correlates and Precursors

Main and Hesse (1990) proposed that frightening or frightened parental behaviour is the primary cause of disorganized infant attachment. However, all the evidence regarding the correlates and precursors of disorganized attachment are correlational rather than causal. Thus the findings will be discussed in terms of associations and correlations rather than causation. Lyons-Ruth, Repacholi, McLeod, and Silva (1991) suggested that infants with disorganized attachment could be placed into subcategories based on a secondary attachment classification of secure or insecure. They found that maternal childhood histories were highly correlated with the disorganized subcategory in which the infant was placed. For instance, mothers who had histories of unresolved loss of a parent tended to have infants with disorganized attachment with a secondary classification of secure. On the other hand, mothers who had histories of childhood abuse, foster care, or domestic violence tended to have infants with disorganized attachment with a secondary classification of insecure. Lyons-Ruth et al. (1991) found that a distinction also exists between both the maternal and the infant behaviours displayed in the two disorganized subcategories. Mothers of infants with disorganized-secure attachments tended to exhibit more withdrawing and frightened behaviours and their infants displayed primarily disorganized behaviours. Mothers of infants with disorganized-insecure attachments exhibited more negative/intrusive and role

confusion behaviours and their infants tended to display disorganization and avoidance.

A number of maternal factors have been associated with disorganized attachment. Not surprisingly, child maltreatment has been one of the most apparent examples of frightening behaviour, and a strong association between maltreatment and disorganized attachment has been observed (van IJzendoorn et al., 1999). Although not all infants with disorganized attachment have abusive parents, van IJzendoorn et al. indicated in their meta-analysis that 48% of children who were maltreated were also disorganized. Across the small number of studies included in the meta-analysis, the percentage of disorganized attachment due to maltreatment ranged from 32% to 86% (van IJzendoorn et al.).

Another factor that has been found to be highly associated with the emergence of disorganized attachment is unresolved loss or trauma in the parent (van IJzendoorn et al., 1999). It is believed that a parent with unresolved loss or trauma (e.g., death of a parent or child, abuse) can exhibit frightening, frightened, or dissociated behaviours because of an inability to control his/her experience of frightening memories or emotions regarding past trauma or loss (Main & Hesse, 1990). Specific forms of loss or trauma that have been suggested as precursors to disorganized infant attachment include loss of a parent or caregiver before age 16 years (Main & Hesse, 1990) and current conflict or domestic violence between parents (Owen & Cox, 1997). It is not the loss or trauma itself but rather the lack of psychological resolution over the loss or trauma and attendant absorption and

negative affect that leads to disorganized attachment (Lyons-Ruth & Jacobvitz, 1999).

Parental depression has also been considered to be linked to disorganized infant attachment. More specifically, it is believed that parental depression is associated with less sensitive parental behaviour because a depressed parent is thought to be more focused on themselves and less attuned to their infant (Crockenberg & Leerkes, 2000; Lyons-Ruth & Jacobvitz, 1999; van IJzendoorn et al., 1999). Several studies have examined the link between disorganized infant attachment and parental depression and the results have been mixed (van IJzendoorn et al.). What appears to be the critical factor in the link between maternal depression and disorganized infant attachment is the degree of clinical impairment shown by the depressed mother (Lyons-Ruth & Jacobvitz). That is, the more chronic and severe the parent's depression, the greater the likelihood of disorganized attachment in the child.

Other maternal factors identified as precursors of disorganized infant attachment include single parenthood (Carlson, 1998) and young maternal age (van IJzendoorn et al., 1999). These relationships may exist because of increased parenting difficulties due to life circumstances experienced by single parents and young mothers. In addition, many single parents and young mothers are of low socio-economic status, which increases the risk for disorganized infant attachment (Carlson, 1998; van IJzendoorn et al., 1999). Mothers with alcohol or drug abuse problems have infants who are at increased risk for disorganized attachment (van IJzendoorn et al.). However, neither maternal history of medical or psychological

problems before or during pregnancy or delivery complications appears to contribute to disorganized attachment in infants (Carlson).

Child characteristics also play a part in disorganized attachment. In clinical samples, the percentage of disorganized infant attachment is higher than in the general population. As noted previously, infants with neurological abnormalities such as cerebral palsy, autism, and Down's syndrome are at increased risk for disorganized attachment (van IJzendoorn et al., 1999). What have not been shown to contribute to the development of disorganized infant attachment are constitutional or temperamental characteristics of the infant (e.g., Carlson, 1998; van IJzendoorn et al.), severe infant physical conditions such as congenital heart disease (van IJzendoorn, Goldberg, Kroonenberg, & Frenkel, 1992; van IJzendoorn et al.1999), and gender of the child (e.g., van IJzendoorn et al.).

Treatment

The treatment of interest in this study was Modified Interaction Guidance (MIG; Benoit et al., 2001), which is based on the principles of Interaction Guidance (IG; McDonough, 2000). Both IG and MIG are mental health services created for infants, children and their families and are considered tertiary interventions. There are three levels of intervention, universal/primary, secondary, and tertiary. In infant mental health, primary interventions are preventative and focus on improving such things as child development and parental knowledge and behaviour (Zeanah, Nagle, Stafford, Rice, & Farrer, 2004). Examples of primary interventions include such things as videotapes and books on attachment or child development, infant massage, and Parent-child Mother Goose. A goal of primary interventions is to

strengthen the caregiver-child relationship. Secondary interventions are aimed at families who are at risk for developing social or emotional problems that could lead to infant mental health problems and promote treatment at an early stage (Zeanah et al., 2004). The goal of secondary interventions in infant mental health is to provide developmental relationship focus. Examples of secondary interventions include such things as Watch, Wait, and Wonder (WWW; Cohen, Lojkasek, Muir, Muir, & Parker, 2002) and the Circle of Security (Cooper, Hoffman, Marvin, & Powell, 1998). Watch, Wait, and Wonder is an infant-led approach used to facilitate and foster caregiver sensitivity and responsiveness (Cohen et al., 2002). Based on attachment theory and research on parent-child relationships, the Circle of Security is a video-based intervention designed to help parents understand the needs of their children (Cooper et al., 1998). Tertiary interventions focus on children and their caregivers who are currently experiencing problems such as difficulties in the parent-child relationship or recent trauma and attempt to prevent or lessen future problems (Zeanah et al.). Examples of tertiary interventions include such things as IG and MIG.

Interaction Guidance is an intervention created to address parent-child relationship disturbances particularly among caregivers who have had difficulty engaging in or have refused more traditional methods of treatment, such as psychotherapy (McDonough, 2000). These families often experience a number of psychosocial problems such as poverty, poor education, family mental illness, substance abuse, inadequate housing, single parenting, and inadequate social support (McDonough). Interaction Guidance was found to be successful for families in which infants have a failure to thrive, pediatric regulatory problems (e.g., feeding,

sleeping, or excessive crying), biological vulnerabilities (e.g., effects of substance exposure in utero), or genetic disorders (e.g., Down's syndrome) (McDonough). Caregivers who were resistant to traditional psychotherapy, young or inexperienced, or cognitively impaired responded well to this form of treatment (McDonough).

Modified Interaction Guidance is a family-oriented, skills based treatment program originally developed to treat infants with feeding problems thought to be the direct result of disrupted parent-infant communication (Benoit et al., 2001). Interaction Guidance was modified to specifically improve the caregiver's ability to monitor and accurately perceive a child's cues and signals, respond to these infant cues and signals in a sensitive and appropriate manner, and reduce disrupted or atypical parental behaviours, all of which promote healthy parent-child attachment systems. In addition, MIG incorporated an individually tailored education component in which parents received additional instruction in topics such as parenting, child development, safety, and feeding behaviours.

Modified Interaction Guidance (Benoit et al., 2001) was created for caregivers who were identified as having disrupted communication as assessed with the AMBIANCE (Bronfman, Parsons, & Lyons-Ruth, 2000). Treatment involves the primary caregiver and infant, and consists of one 60 to 90 minute session per week for 6 to 8 consecutive weeks. At each session, a 10-minute play session between the caregiver and the infant is videotaped. The caregiver is instructed to play with the infant as they normally would at home. Following the play session, the therapist reviews segments from the videotaped session with the parent, particularly segments showing appropriate parenting behaviours (90% of session) and disrupted

or atypical behaviours (10% of session). Working with the caregiver to modify specific atypical behaviours, the therapist provides the caregiver with feedback, suggestions, and education. Between visits, caregivers are asked to practice what they have learned and provide feedback at next meeting.

Therapeutic and Learning Processes

The Generic Model of Psychotherapy (Orlinsky, Grawe & Parks, 1994) was developed to describe commonalities across the many types of psychotherapies. The model describes the relationship between three components common to all psychotherapies: inputs, processes, and outcomes (Kolden, 1996). Inputs include the pre-treatment characteristics of the parent and clinician within the context in which therapy occurs (Orlinsky et al., 1994). Outputs are observed outside the client-therapist relationship and focus primarily on treatment outcome. Outputs include the client's post-session and post-treatment outcome, and the current psychological functioning and life situation (Orlinsky et al.). More specifically, treatment outcome refers to the changes in the psychological, somatic, physical, social, and cultural conditions of the client that reflect positive or negative effects of therapy on the client's well-being (Orlinsky et al.). Processes link inputs and outputs.

Orlinsky et al. (1994) differentiate between therapeutic processes and change processes. Change processes are the "processes of change through which clients or patients are hypothesized to improve" (Orlinsky et al. 1994, p. 274) and are processes that occur within the individual but not necessarily during therapy sessions (Orlinsky et al.). Greenberg (1986) suggests that process of change research focuses not on what is occurring in therapy or whether therapy is working

but rather on the "effects of the processes that bring about therapeutic change over the entire course of therapy" (p. 4). More simply, Kolden (1996) states that change processes refer to how therapy works. The concepts of motivation and readiness to change are two examples of change processes and are well-researched topics in psychotherapy and highly correlated with outcome (Prochaska, 2000). Prochaska proposes that change occurs over a series of five stages: precontemplation, contemplation, preparation, action, and maintenance. Prochaska states that an individual is in the precontemplation stage if there is no intention for change in the near future. These individuals tend not be unaware that a problem exists. Individuals in the contemplation stage recognize that a problem exists and is thinking about making a change but has not committed to take action. In the preparation stage, individuals are seriously committed to taking immediate action and have begun to make small behavioural changes. Those individuals in the action stage put in a considerable amount of time and energy to modify their behaviour, their thinking, their experiences, and their environment to overcome their problem. In the maintenance stage, individuals continue to work to prevent relapse. Prochaska states that these stages do not progress linearly but rather follow a spiral pattern as individuals often relapse and regress to an earlier stage. In addition, it has also been established that individuals in the action stage at the beginning of treatment were less likely to prematurely terminate the treatment than those in the precontemplation and contemplation stages (Prochaska, 2000). Another example of change processes is the therapeutic bond. The therapeutic bond has been shown to be associated with several factors. For instance, research has shown there to be a significant positive

association between the therapeutic bond and such things as patient cooperation, motivation, and self-exploration, treatment duration, and treatment outcome (Orlinsky et al., 1994).

The therapeutic processes refer to events that are observed and experienced in therapy sessions (Orlinsky et al., 1994). Therapeutic processes are the characteristics or components of therapy and are interrelated with one another. Orlinsky et al's. Generic Model of Psychotherapy includes six aspects of processes that are likely to be found in most forms of psychotherapy. These include the therapeutic contract, the therapeutic operations, the therapeutic bond, self-relatedness, in-session impacts, and sequential flow. The therapeutic contract reflects decisions regarding contractual provisions and implementation. Contractual provisions include aspects such as scheduling of sessions, duration of therapy, and fees for treatment. Contractual implementation includes formation of goals, and client and therapist role preparation. The therapeutic operations are the processes that occur as the client presents to the therapist the problem that led to seeking treatment, the therapist uses expert knowledge to create an intervention for the client, and the client cooperatively participates in this intervention to attain a positive outcome. The therapeutic bond reflects the degree of participation and personal involvement by those in the client and therapist roles, the extent to which the client and therapist have empathic understanding of each other, and the mutual respect in the relationship (Kolden, 1996; Orlinsky et al.). Self-relatedness refers to the ways in which the client and the therapist respond to internal events such as their thoughts and emotions. The in-session impacts are the client's positive and negative moment-

to-moment experiences within the session. These moment-to-moment experiences are called therapeutic realizations and include attainment of insight, unburdening, and problem clarification (Kolden, 1996), which are the client's positive in-session experiences (Orlinsky et al.). The sequential flow refers to the development of sessions, the stages of treatment, and the duration of treatment (Orlinsky et al.).

The present study explored not only the therapeutic processes that occurred during therapy but also the learning processes that occurred while the clinician learned and implemented MIG and received supervision. Learning could occur because of the interactions between the inputs, that is, the clinician's personal and professional characteristics, and the self-relatedness processes, that is, the clinician's ability to change her own behaviour in response to feedback from the client and supervisor and reflect on her own thoughts and emotions.

Early on in the design of the present study, there were certain presuppositions about the client, the clinician, and the dyad that guided the design of some of the data collection measures. For instance, it was thought that client motivation and readiness to change may influence the outcome of therapy and thus were addressed in the client and clinician questionnaires. For this study, it was important to examine if readiness to change was a factor in the outcome of MIG. The client's readiness to change was assessed from the perspectives of the client and the clinician. As a paraprofessional would be learning and administering MIG, it was relevant to explore how the clinician's academic and work experience played a role in the implementation of MIG. Questions that were pondered included, "what skills and experiences does the clinician have that would impact the therapy or the

relationship in a positive way?" and "what important clinical skills is the clinician lacking?". The client and clinician characteristics are aspects of the input component of the Generic Model. Considering the importance of the therapeutic bond on outcome in psychotherapy (Orlinsky et al., 1994), the relationship between the parent and the clinician was also explored. As this was the clinician's first time using MIG with a parent, a question that was considered was "how effective would this clinician be in creating an accepting, nonjudgmental, insightful, affirming, and professional atmosphere for the parent?". Assessing this question from the perspective of both parent and clinician helped to create a better understanding of the clinician's skills and how the therapeutic bond influenced different aspects of the parent's outcome.

CHAPTER TWO: THE PRESENT STUDY

History

The Prince George Attachment Project, spearheaded by Dr. Hardy, began in 2001 when Dr. Hardy attended an infant mental health workshop in Calgary presented by psychiatrist Dr. Benoit, from the Hospital for Sick Children, Toronto. In this workshop, Dr. Benoit described disorganized attachment in caregivers and children and explained the utility of MIG as a treatment for reducing or eliminating disrupted communication errors in caregivers. After having completed a program evaluation of Parent Project North in 2001 (Hardy & Webb, 2001) and having an understanding of the gaps in services for children and families in Prince George, Dr. Hardy recognized the need for attachment work in this community. Early in 2002, Dr. Hardy collaborated with Cindy Ignas at Parent Project North to develop a Community Action Plan in response to disorganized attachment. Dr. Benoit visited Prince George in June 2002 and presented a two-day workshop on infant mental health and MIG. Later that year a team of local professionals with experience in child and infant development, mental health, and parenting, including Dr. Hardy, came together with the goal of learning more about disorganized attachment and potentially implementing MIG in their own organizations. At that time, the team began to learn the AMBIANCE coding system, first with Dr. Benoit and later with Dr. Sonya Vellet who was trained by Dr. Benoit. The team continued learning AMBIANCE until late 2003. Late in 2004, Dr. Vellet visited Prince George and presented a two-day workshop on assessment and intervention strategies related to parent-infant child attachment. As a thesis student working with Dr. Hardy, I joined

the Prince George Attachment Project at the beginning of 2003 as a researcher, with the goal of capturing the processes that emerged during the team's experience of learning and implementing MIG with a parent.

Purpose of the Study

MIG has been shown to be a highly effective intervention when administered by an infant psychiatrist with particular expertise in attachment theory (Benoit et al., 2001); however, the generalizability of MIG to different contexts and settings needed to be studied. The need for MIG in the community of Prince George could be seen by examining the expected prevalence of disorganized attachment. The prevalence of disorganized attachment in children was estimated to be approximately 15% among middle-class families and 25% among lower-class families (van IJzendoorn, 1999). Given 1,039 live births in Prince George for the year 2002 (BC Vital Statistics, 2002), application of these boundaries of 15% to 25% yields an estimate of between 146 to 260 children born in 2002 who are likely to develop disorganized attachment. For all of BC, between 5,585 and 9,974 of the 39,893 children born in 2002 (BC Vital Statistics, 2002) may develop disorganized attachment. The challenges of responding to this need revolved around the skills and expertise required to deliver effective services. To date, MIG has been evaluated exclusively when delivered by mental health professionals with expertise in attachment theory (Benoit et al., 2001). The process of learning MIG has yet to be documented. The importance of addressing this issue in northern BC is that it is not clearly understood what training is required of non-experts in attachment implementing MIG and what supports need to be in place to ensure safe effective services for families.

The purpose of this study was to describe the therapeutic and learning processes that unfolded during MIG sessions and supervision as a paraprofessional, who was a non-expert in attachment, learned to administer MIG. A goal of this study was to identify and describe key clinician and parent variables or characteristics thought to be related to therapeutic and learning processes involved in MIG. Clinical outcome for the family was evaluated in order to understand the ways in which therapeutic processes of MIG influence parental behaviour. This thesis was the first step in a larger ongoing project designed to gather information about the learning and therapeutic processes of MIG and share this knowledge with other clinical teams wanting to learn and provide MIG to clients, particularly clinical teams that reside in northern, rural and/or remote communities.

The present study was a descriptive and exploratory case study. The clinical team receiving MIG training and supervision were considered the case and the individual participants, the dyads, and the clinical team were the units of analysis. Data collection and analyses for this study took place during all phases of clinical supervision in MIG. Data for this case study were collected from the treating clinician, the parent, the observing clinician (the treating clinician's program manager), and Dr. Vellet, the supervising psychologist. The information collected was both qualitative and quantitative in nature. Rating scales provided data regarding the level of disrupted communication pre- and post-treatment. Data, in the form of open-ended questionnaires, were collected from both the clinician and the parent. In addition, data were obtained from field notes from the audioconference sessions and from the journal notes that the clinician completed after each session.

Lastly, data were collected from semi-structured interviews conducted with the treating and observing clinicians and the supervising psychologist. The analysis focused on the processes and the identification of themes, concepts, and patterns of behaviour using thematic analysis.

My Story

In qualitative research, an important aspect of data analysis and the presentation of the results that must be taken into consideration are one's subjective biases, thoughts, values, and opinions. As I initially began to read through the data and later began writing the discussion, I had to think about the things in my own life that influenced my interpretation of the results. First and foremost, I am a mother of a young child. As I entered into motherhood, I became aware of a newly emerging sensitivity to issues regarding children. As I watched the videotaped play sessions or read through comments made by the parent, I reacted emotionally at times to the parent's thoughts and behaviours regarding her relationship with her child. As much as this affected me, I could at the same time relate to the parent's struggle in making cognitive and behavioural changes with her parenting. Although my struggles with parenting were different than this parent's, the underlying processes of parenting are relatively similar. As I read the parent's responses regarding motivation prior to and after finishing the intervention, I felt empathy for this parent, as her difficulties in parenting paralleled my own struggles. Lastly, I entered this project as a student and a researcher. My observations and assessments of MIG, the sessions, and supervision differ from the clinicians'.

CHAPTER THREE: METHOD

This study used a case study methodology with qualitative and quantitative data collection approaches. The case in this study was the clinical team, in Prince George, British Columbia, who received MIG training and supervision from a clinical psychologist. More specifically, the units of analysis within this case were the individuals participating in this study, the parent-child, the clinician-parent, and the clinician-supervisor dyads, and the clinical team.

The case study is a useful research method in qualitative research for a number of reasons. The case study offers a rich, in-depth look into a "case", which can be an individual, a group, a program, or even an institution (Miles & Huberman, 1994) and highlights the uniqueness of that which is being studied (Searle, 1999). The case study can be used to explore topics or issues that cannot be studied through experiment due to ethical considerations and can provide a plethora of detailed information that can lead to further study (Yin, 1993). Yin (1993) suggests that a case study is an appropriate research method for an investigator to use if the topic of study is broadly defined, the context in which the case is bounded is included to be studied, and the study needs multiple sources of data, which can be qualitative, quantitative, or both, to capture the richness of the case. The case study was an appropriate research method for this thesis as the purpose of the study was to explore and describe a broad topic, learning and therapeutic processes. The team's context, in which supervision took place, was incorporated into the study, and both qualitative and quantitative methods of data collection were used to explore the purpose and goal of the study.

Participants

The participants for this study were one treating and one observing clinician, one parent who received treatment, and Dr. Sonya Vellet, the supervising psychologist. The clinicians were from Northern Health and had been working with Dr. Hardy for over 3 years to learn the associated theory and techniques involved in MIG. The treating clinician provided direct treatment to the client while the observing clinician assisted with equipment, research activities, and childcare. Dr. Vellet, a child psychologist based in Calgary, supervised the team via teleconference after some face-to-face workshops in Prince George.

Before a potential parent was selected from the clinician's active caseloads, the clinician was to decide whether a given parent-child dyad was suitable for the MIG project and research study (see Appendix A, Inclusion/Exclusion Criteria Checklist, p. 92). Suitable families included those in which a child 7 years of age or younger was suspected of having a disorganized attachment relationship with the parent who would be involved in MIG, and the parent was likely to be receptive to participating in supervision and research activities. Parents who had an active file with the Ministry of Children and Family Development (MCFD) due to child protection concerns were excluded. Additional reasons for families to be excluded included the parent: 1) having a history of violence or aggression towards the child; 2) being actively engaged in addictive behaviours that are harmful to the child (e.g., substance abuse); 3) having acute psychotic, acute and severe depression, or known to have borderline personality disorder; and having ongoing forms of other treatment for self (e.g., psychotherapy focused on the parent). The parent in this

study was a mother who participated with her daughter, aged 5 years. The clinicians and the parent gave full informed consent to participate in the study before data collection procedures began. To maintain confidentiality and privacy, the parent was identified to the researcher only through a number (Client 1a).

Procedure

Informed consent. Prior to parent recruitment, the researcher met with the treating and observing clinicians to discuss the Clinician Information Sheet (see Appendix A, pp. 93-94), which addressed the purpose of the study, what participation entailed, and ethical issues. The clinicians were informed that participation was purely voluntary and they had the right to withdraw at any time without giving a reason. Both the clinician and the researcher signed the consent form in duplicate and were given a copy of the information sheet to keep. Dr. Vellet also consented to participate in this research project.

During the first meeting with a potential parent, the observing clinician was introduced to the parent to discuss the research project. The clinician went over the research project using the Client Information Sheet (see Appendix A, pp. 96-98), which addressed the purpose of the study, what participation entailed, and ethical issues. The parent was informed that if the assessment resulted in a recommendation for MIG treatment, only then would the parent be invited to participate in the research. As discussed in the next section, maternal disrupted communication was observed in the parent-child play session and a recommendation of MIG was given to the parent.

After the parent consented to MIG treatment, the observing clinician spent roughly 20 minutes with the parent discussing research participation. The observing clinician reviewed the Client Information Sheet with the parent and answered any questions. The parent was informed that participation was purely voluntary and had the right to withdraw at any time without giving a reason. Both the clinician and the parent signed the consent form in duplicate (one copy for the researcher and one copy for the parent) and the parent was given a copy of the information sheet to keep. The copy for the researcher was placed in an envelope and kept by the clinician until treatment was completed.

Data collection. The information that was gathered from the participants was obtained before, throughout, and after treatment. Prior to approaching potential parents, the clinicians were emailed a copy of the Academic and Work Experience Questionnaire which, when completed, were emailed back to the researcher. Once a suitable parent was identified, a 10-minute parent-child play session, used to evaluate disrupted communication displayed by the mother, was videotaped. The clinical team reviewed this videotaped play-session and completed the Disrupted Communication Rating Scale. Dr. Vellet was involved in this process and also provided a disrupted communication rating for this parent. The team concluded that disrupted communication was probably present and recommended MIG to the parent.

At the beginning of the first MIG session, the clinician helped the parent complete the Pre-treatment Client Questionnaire. After this first session was

finished, the clinician completed the Pre-treatment Clinician Questionnaire and started a journal, which continued throughout treatment with the parent.

At the end of the last MIG session, the treating clinician left the room while the observing clinician assisted the parent with completion of the Client Rating of Improvement Scale and Post-treatment Client Questionnaire. The questionnaire included questions about the clinician so it would be methodologically unsound to have the clinician administer it. The parent completed the questionnaire in private with the observing clinician available to answer questions, as needed. After completing the questionnaires, the parent sealed the package to maintain confidentiality and gave it to the observing clinician before leaving the building. While out of the room, the treating clinician completed the journal and the Clinical Rating of Improvement Scale. The observing clinician collected the paperwork from the treating clinician and the parent, placed it in the envelope containing the parent consent form, sealed the envelope and signed the flap. The sealed envelope was given to the treating clinician and was locked in a cabinet in the clinician's office until picked up by the researcher. Once the researcher obtained the envelope, it was kept locked in Dr. Hardy's laboratory until thesis work was completed.

Shortly after treatment with the parent had concluded, the researcher interviewed the supervising psychologist via telephone. The interview was tape-recorded and detailed notes written up. Next, the researcher met with the treating clinician at the clinician's place of work to do the post-treatment interview. This interview was tape-recorded and notes transcribed verbatim. As a result of busy work schedules, the researcher met with the observing clinician 3 months after

treatment with the parent ended. This interview was tape-recorded and notes written up. Due to poor sound quality on parts of the audiotape, the clinician subsequently responded to two of the interview questions via email at the researcher's request.

The parent-child play sessions and the clinician-parent feedback sessions were videotaped for supervision and research purposes. The session videotapes were brought to UNBC, copied in private by a research assistant, and the copies sent to the supervising psychologist. To safeguard parent privacy, the videotapes were sent via courier with a prepaid return waybill enclosed. The supervisor returned the videotape to Dr. Hardy immediately after the supervision session. Original and copied videotapes were stored in Dr. Hardy's laboratory at UNBC in a locked cabinet and destroyed at the end of the data analysis phase of the study.

Data Collection Approaches

Academic and Work Experience Questionnaire. At the beginning of the study, the participating clinicians were asked to complete the Academic and Work Experience questionnaire (see Appendix B, p. 106). Documentation of the clinician's prior skills and knowledge aided in evaluating links between the clinician's characteristics and the learning and therapeutic processes that evolved.

Disrupted Communication Rating Scale. The AMBIANCE (Bronfman, Parsons, & Lyons-Ruth, 2000) is a coding protocol used to code atypical maternal behaviour during a play session or Strange Situation. The AMBIANCE provides a summary score based on evaluations of atypical behaviours along five different dimensions: affective communication errors, role/boundary confusion, frightened/disoriented behaviour, intrusiveness/negativity, and withdrawal. A

qualitative rating from 1 to 7 is given by the coder to summarize the amount and severity of disrupted communication. Scores ranging from 1 to 4 signify a classification of not disrupted and a score ranging from 5 to 7 signify a classification of disrupted communication. A mother may display few atypical behaviours but still receive a classification of disrupted because the atypical behaviours that she displayed were both serious and disturbing. Inter-rater reliability was good with r = .75 when done by Lyons-Ruth et al. (1999) and r = .77 when done by Benoit et al. (2001). In a study examining the usefulness and efficacy of the AMBIANCE, scores on the AMBIANCE measure correlated with the treatment outcomes as expected providing evidence of construct validity (Benoit et al., 2001).

The clinical team involved in the present project had been working for over 3 years to master the AMBIANCE coding system. However, the clinical team had not tested their reliability because of concerns about the AMBIANCE training materials, and concerns about the practical utility of maintaining competence in use of the AMBIANCE system over the long term. The training materials were videotaped samples of parent-child interaction, provided by Dr. Benoit, previously coded by reliable coders in Dr. Benoit's research team. Training involved review, discussion, and blind coding of the samples with subsequent comparisons to the ratings provided by the reliable coders in Dr. Benoit's team. The main difficulties encountered with the training materials were poor sound and visual quality. Oftentimes these problems occurred in areas that had significant impact on critical coding decisions (e.g., when mother's voice reflected fear). Further, some of the coding decisions that were represented in the training materials seemed to be

errors. This left trainees in the position of being unable to differentiate coding errors from occasions where poor sound and visual qualities made coding agreements difficult. Concerns about the practical utility of maintaining competence in use of the AMBIANCE system over the long term arose as trainees saw that breaks (e.g., during summer holidays) from the work of coding resulted in significant deterioration of coding skills. Other researchers had experienced similar problems with the AMBIANCE and created a rating scale that made the system more user-friendly and ready for implementation in clinical settings (Madigan, Evans, Bento, Oliphant, Pederson, & Moran, 2004).

Although the Prince George clinical team did not feel that it was worthwhile to continue pursuing research-levels of reliability on the AMBIANCE, they noted that their ratings were often very close to the ratings provided by Dr. Benoit's team. The clinical team was often accurate in evaluating communication that was significantly disrupted (6 or more) or not disrupted (3 or less). However, at the cut-off between not disrupted and disrupted (4 versus 5), the team experienced more difficulty. The atypical behaviours that separated the ratings of 4 versus 5 were sometimes very subtle and the distinctions often seemed to be a matter of personal opinion. For these reasons, the AMBIANCE rating scale was collapsed into a 3-point scale for the purposes of this study. Working together, the team and the supervisor made clinical ratings of disrupted communication on the 7-point AMBIANCE scale, which were then also translated into the 3-point modified scale. The team's AMBIANCE rating, when compared to the supervisor's rating, was used primarily to obtain a sense of the team's ability to use the AMBIANCE scale reliably. The modified scale, called the

Disrupted Communication Rating Scale (see Appendix B, p. 107), ranged from: 1) no need for treatment (3 or less on the AMBIANCE's disrupted communication scale); 2) may benefit from treatment because has some signs of disrupted communication (4 or 5 on the AMBIANCE scale, which is the cutoff between not disrupted and disrupted communication); and 3) high need for treatment (6 or above on the AMBIANCE). Parents rated as 2 or 3 on the Disrupted Communication Rating Scale would be recommended for treatment with MIG; parents rated as 1 on this scale would not be recommended for MIG. Parent-child play sessions videotaped prior to treatment and during the last treatment session were reviewed by the clinical team (excluding the treating and observing clinician) at end of treatment for the purposes of obtaining an independent rating of degree of disrupted communication. The purposes of this rating were to evaluate the level of disrupted communication displayed by the parent when interacting with the child before and after treatment and to document the degree of improvement in parenting behaviours post-treatment. As a reliable coder of AMBIANCE, Dr. Vellet provided her ratings to confirm the ratings given by the team.

Pre-treatment Client Questionnaire. In the first MIG session, the clinician asked the parent a series of questions regarding the parent's opinions and goals for treatment, and level of motivation (see Appendix B, p. 108). The purpose of these questions was to assess how the parent felt about receiving treatment, to identify the changes the parent wanted to occur, and the parent's readiness to change. Two questions addressed level of motivation and response to these questions were on a 5-point likert scale with 1 = not at all motivated and 5 = very motivated. This

permitted evaluation of the parent's attitudes towards MIG and helped the treating clinician tailor MIG to the parent's individual needs. For research purposes, the questions asked in the first session helped identify parent characteristics and aided in understanding the link between parent characteristics, therapeutic processes, and treatment outcome.

Pre-treatment Clinician Questionnaire. At the end of the first session with the parent, the clinician responded to a question regarding the therapeutic alliance using a 5-point likert scale with 1 = poor- lack of trust is a major barrier to treatment; 2 = Fair – trust is sufficient enough to start treatment; 3 = Good – have started to build a relationship; 4 = Strong – relationship will withstand some challenges; and 5 = Very Strong = relationship will support change. In addition, the clinician also responded to a question regarding the clinician's perceptions of the parent's stage of change (Prochaska, 2000) that the clinician believed the parent to be in. The stages of change are: 1) preparation; 2) contemplation; 3) preparation; 4) action; 5) maintenance; and 6) relapse. The clinician rating served as a comparison to the parent's rating of readiness to change. The purpose of the questions on the Pre-treatment Clinician Questionnaire was to assess, from the clinician's perspective, the strength of the therapeutic relationship and the parent's readiness to change parenting behaviours (see Appendix B, p. 109). This questionnaire evaluated the links between parent and dyadic factors, therapeutic processes, and treatment outcome.

Clinician's Journal. Throughout the study, the clinician was asked to keep a journal of learning experiences while providing treatment and participating in supervision (see Appendix B, p. 110). This journal provided insight into therapeutic processes, detailed the clinician's thoughts about her own clinical skills, and described the parent's response to treatment. The researcher crossed out any names mentioned in the journal with a black marker to maintain privacy and confidentiality.

Client Rating of Improvement Scale. At the end of the last session, the observing clinician provided the parent with a package containing the Client Rating of Improvement Scale (see Appendix B, p. 111). Using a 5-point rating scale, where 1 = much worse; 2 = somewhat worse; 3 = no improvement; 4 = somewhat improved; and 5 = much improved, the parent rated her own degree of improvement in parenting behaviours. This rating served as a comparison to the clinician's rating of improvement and was used to assess treatment outcome from the parent's perspective.

Post-Treatment Client Questionnaire. Included in the package containing the Client Rating of Improvement scale was the Post-treatment Client Questionnaire (see Appendix B, pp. 112-113), which assessed the parent's opinions about the treatment and the clinician. The purpose of this questionnaire was to obtain information about how MIG was perceived by the parent and identify clinician and dyadic factors linked to the therapeutic processes. Responses helped the researcher identify ways that MIG-based treatments might be modified in the future.

Clinical Rating of Improvement Scale. At the end of the last session with the parent, the treating clinician, using the same 5-point rating scale as the parent, rated the degree of improvement in the parent's parenting behaviours (see Appendix B, p. 114). The parent and clinician ratings served to cross-reference the team's ratings based on the disrupted communication scale. This scale was used to assess treatment outcome from the clinician's perspective.

Supervisor and Clinician Interviews. The clinicians and the supervising psychologist were interviewed at the end of active treatment with the parent. The interview with the treating clinician focused on the processes of providing MIG treatment and the experiences of the clinician while administering MIG (see Appendix B, pp. 115-117). The interviews with the observing clinician and the supervisor focused on perceptions of the MIG treatment, opinions about the supervision sessions, challenges experienced while learning MIG, and future implications. In conjunction will all other data sources, this information was used to evaluate key clinician, parent, or dyadic characteristics and additional factors thought to foster and hinder the success of the intervention. In addition, the interviews served as a tool for understanding the learning processes involved as the team learned MIG.

Field notes. Three supervision audioconference sessions occurred and many email communications were written between Dr. Hardy, the treating clinician, and the supervising psychologist. Dr. Hardy and the researcher took notes during these audioconference sessions, which were used to document the content of the

sessions. In addition, the email communications were studied for content and used to supplement the clinician's journal.

Data Analysis

The present project was a case study where the case was the clinical team in Prince George, British Columbia, who received MIG training and supervision from a clinical psychologist. More specifically, the units of analysis within this case were the individuals participating in this study, the parent-child, the clinician-parent, and the clinician-supervisor dyads, and the clinical team. More specifically, the participant's and clinicians' responses and the clinician-parent dyad were closely examined in order to provide insight into the therapeutic and learning processes as the treating clinician learned to implement MIG. The supervising psychologist was interviewed to provide insight into the learning and therapeutic processes that unfolded. Notes of the audioconferences and email communications were used to assess the challenges experienced by the clinical team as they learned MIG. To assess whether MIG modified relevant parenting behaviours, the three ratings of outcome for the parent, provided by the clinician, the parent, and the clinical team, were compared and contrasted. To identify key clinician and parent characteristics thought to be related to therapeutic and learning processes involved in MIG, open-ended questionnaires, semi-structured interviews, field notes, and a journal kept by the clinician were analyzed.

As relevant data regarding the research goals were gathered, the information was compiled, sorted, and analyzed continuously using thematic analysis to identify and pull together emerging themes, patterns, concepts, or explanations (Creswell,

1998). Once the data were compiled, the material was read through several times, first to get a feel for the material and then several times again to sort and make sense of the material. As they came to mind, memos of thoughts, ideas, or interpretations about the information were added to the margins of the questionnaires, field notes, interview transcripts, and clinician's journal to keep the data focused and comprehensible. All of the material was broken down into its basic parts making the process of deciphering and classifying the material more manageable. The data were then catalogued into tables, which helped for visualizing the patterns and identifying the themes and sub-themes that emerged. Throughout data collection and analysis the themes and sub-themes were revised until a small number of overarching themes were created. As data analysis progressed, several case analysis meetings (Miles & Huberman, 1994) were held with Dr. Hardy to summarize and validate the themes, patterns, concepts, or explanations that emerged from the case. Data collection and analysis took approximately 8 to 10 months.

Reliability and Validity

As in all research, careful consideration must be given to establishing the reliability and validity of a study. For this case study, a number of techniques were used during data collection and analysis to ensure that construct validity, external validity, and reliability were achieved. Reliability refers to the consistency with which the operations of a study can be replicated, yielding the same results (Yin, 1993). To ensure reliability in this case study, the research procedures used were carefully documented. A further check of reliability was the use of triangulation, which refers

to the use of more than one source of evidence so that "data triangulate over the facts of a case" (Yin, 1993, p. 67). That is, all the sources of evidence should essentially say the same thing and discrepancies analyzed. In this case study, method triangulation was used (Miles & Huberman, 1994). That is, data were collected using a number of sources such as semi-structured interviews, rating scales, and questionnaires. Also important in all research is validity. Validity refers to meaning, for example, whether we are measuring what we think we are measuring (Searle, 1999). Methods used to increase validity of this study were use of multiple sources of evidence and several case analysis meetings with Dr. Hardy to discuss the findings, my interpretation of these findings, and address questions regarding the data.

CHAPTER FOUR: RESULTS

The purpose of this study was to document the therapeutic and learning processes that emerged while a paraprofessional who was a non-expert in attachment learned to implement MIG with a goal being to identify and describe key clinician and parent characteristics thought to be related to the therapeutic and learning processes involved in MIG. As part of a larger project, the goal of this study was to disseminate this information to other teams wanting to learn and implement MIG. The results are organized into sections that summarize a) the parent's pre-treatment profile; b) the clinicians' prior academic and work experience and skills; c) the assessment phase, when the parent was first selected as a learning case; d) the active treatment phase; e) the post-treatment phase; and f) the post-supervision phase.

Parent Pre-treatment Profile

The participating parent in this study was a mother in a stable and supportive marriage with two adopted children, ages 5 and 8 years, and one biological child, age 8 months. The mother reported that both older children were on medication for Attention Deficit Hyperactivity Disorder (ADHD). She acknowledged having a history of alcohol abuse and had been sober for 7 or 8 years. The mother also reported being a victim of child sexual abuse and experiencing the loss of her grandparents as a young teenager. She also reported that her own mother had high expectations of her. She stated, "I never pleased mom and my daughter can't please me".

Academic and Work Experience

At the time, the treating clinician in this study had a Bachelor's degree majoring in psychology and was currently a Master's student in an applied but not clinically accredited psychology program. Relevant work experience for this clinician involved working closely with children, parents, and families doing parent education and support. From her academic and supervised work experiences, she had received theoretical and practical training in several areas. Specifically, this clinician had paraprofessional level training in topics relevant to family assessment and was trained in observing and recording child and parent behaviour, and parent-child interactions. Having a good understanding of developmental milestones, the effects of cultural differences, and the effects of past trauma on families were highlighted by the treating clinician as key skills that would help her when administering MIG. She also stated that a very important aspect of her job was to treat families with mutual respect, compassion, and support.

The observing clinician in this study had a Bachelor's degree in criminology and was taking graduate courses in social work. This clinician had extensive experience working with children, parents, and families. In addition, this clinician supervised the treating clinician at their place of work. The theoretical and practical training experienced by this clinician encompassed early childhood development, human development, family systems, and counseling.

Both clinicians attended the two-day workshop presented by Dr. Benoit in 2002. The treating clinician attended the two-day workshop presented by Dr. Vellet in 2004. Both clinicians had spent over one year learning the AMBIANCE coding

system, although they did not test their reliability. Through their involvement with the Prince George Attachment Project, the clinicians became familiar with the literature on disorganized attachment and intervention strategies such as MIG and WWW.

Assessment Phase

Pre-treatment disrupted communication ratings. Prior to the commencement of MIG treatment the clinical team met to evaluate the level of disrupted communication displayed by the parent when interacting with the child. The clinical team (excluding the treating clinician) and the supervisor provided ratings for both the AMBIANCE scale and the modified scale. For the initial parent-child play session, the supervisor rated the level of disrupted communication as 5 on the AMBIANCE scale and the team's rating was 4 or 5. Overall, the clinical team and the supervisor agreed that the level of disrupted communication was 2 on the modified 3-point scale. That is, the team believed that the parent would benefit from treatment because she showed some signs of disrupted communication.

Pre-treatment parent responses. At the beginning of the first MIG session, the parent answered a number of questions regarding her goals for treatment, motivation, definition of success, and level of insight. The parent was able to identify a relational goal that was behaviourally anchored. However, when asked if her parenting behaviours influence her child's behaviour, she stated, "[child's name] behaves in a way to get a response from me". Her response indicated that she did not naturally use a relational framework for understanding her daughter's behaviour. When asked how she would know if treatment was working, the parent responded,

"if I call her name, I expect her to look, such as nodding, some kind of response cause I can't tell when she is responsive".

The parent was asked how motivated she was to make the changes that she and the clinician had discussed and to rate her willingness to make changes in parenting behaviours. For both of these questions, the parent rated her level of motivation as 4 on a 5-point scale. That is, the parent was somewhat motivated to make the changes suggested by the clinician and to change her parenting behaviours.

Pre-treatment clinician responses. At the end of the first session with the parent, the clinician was asked to rate the therapeutic relationship with the parent. The clinician rated the relationship with the parent as 3 on a 5-point scale. That is, the relationship was considered "good – have started to build a relationship". When asked what stage of change the parent was currently in, the clinician described the parent as being in the contemplation phase, characterized by an awareness and recognition that a problem exists without commitment to change (Prochaska, 2000).

Active Treatment Phase

Field notes. The notes from the audioconference supervision sessions, the email communications between Dr. Hardy, the clinician, and Dr. Vellet, and the clinician's journal provided insight into the kinds of questions and issues that emerged through the process of learning MIG. During the audioconference sessions the team discussed some of the parent's case material and the supervisor provided the team with a case conceptualization for the parent. Given the behaviours displayed by the parent in the play sessions, the supervisor identified themes for the

clinician to focus on with the parent. As well, a number of questions were raised by the treating and observing clinicians regarding technical aspects of the treatment. For instance, the treating clinician explained that during the first feedback sessions, the child acted out and did not want to stay in the room. The treating clinician asked Dr. Vellet if it was necessary for the child to be in the room while the parent and clinician reviewed the videotape. Dr. Vellet commented that it was very important that the child be involved in this process. At that time, the clinical team recognized that the child's reaction to watching the videotaped play session symbolized something but they were unsure of exactly what the behaviour meant. Another question that was raised was regarding the time between sessions. Dr. Vellet stated that consecutive weekly sessions were best. In addition, the team addressed questions about audiovisual equipment. Audiovisual equipment questions included camera positioning, recording time on the videotape, and minor glitches (e.g., what to do about the videotape running out during a session). As well, the team asked the supervisor for some advice for starting an attachment network in northern BC.

One of the main forms of communication between Dr. Hardy, the clinician, and the supervisor was email. For the most part, the clinician emailed her questions to Dr. Hardy who then forwarded these questions onto Dr. Vellet. Becoming trained in the techniques of MIG was a learning process for the clinical team so it was not surprising that Dr. Hardy and the clinician had questions or comments throughout this process. For instance, prior to commencing treatment, the clinician was uncertain what types of questions should be asked in the initial intake session. Intake interview content such as obtaining a family history and prenatal history would

be common practice for a psychologist specializing in attachment; however, this was not a process that the clinician was familiar with in this context. As treatment began technical questions emerged regarding videotaping the play and feedback sessions. More specifically, the parent felt "odd" about being videotaped at the beginning of treatment and requested that her back be to the camera. This response by the parent indicated that she was feeling discomfort with being videotaped. Other questions that were emailed to Dr. Vellet were regarding puzzling behaviours exhibited by the parent and the child during the play sessions, the parent's and child's responses to treatment, and techniques of the treatment. The clinician also required direction at times regarding how to proceed with the parent at the next session. Dr. Hardy also commented to the supervisor that she had noticed that the team had expressed emotional responses while watching the videotapes during one of the audioconference sessions. The supervisor replied, "it is good to have the opportunity to debrief about the challenging work". For the most part, the supervisor responded to the questions or comments posed by Dr. Hardy and the clinician within a couple of days. There was however one email in which a response from Dr. Vellet took nearly three weeks. Dr. Vellet replied to this email stating that she had been pondering on how to proceed with the challenging parent-child dyad. She commented that given the complexity of issues that this parent had, it would be best not to continue MIG any further with this dyad.

Clinician's journal notes. The information that the clinician provided in her journal documented therapeutic and learning processes. The therapeutic processes can be described as situations, experiences, or constructs that were experienced by

the clinician and parent or within the clinician-parent dyad during treatment, whereas learning processes are how and what the clinician learned while providing treatment. Therapeutic processes will be discussed first, followed by the learning processes.

In the journal entry regarding the first therapy session, the clinician noted that the session was disrupted after the first few minutes of watching the videotape during the feedback session and that she was unable to keep the child in the room. The clinician reported:

> After the play session was over and we began to watch the film, the child was excited to see herself and mom on the TV, however a couple minutes into the video, [child's name] became very destructive, hitting the TV, she then grabbed a doll and began punching the doll and smashing it into the plastic package for the doll.

Although the clinician felt she had good rapport with the parent, she found it difficult to describe and convey abstract concepts in a way that the parent could understand. The clinician was sensitive to the parent's needs by supporting and calming the child after the disruptive behaviour and acknowledged and empathized with the parent's discomfort in being videotaped. The clinician felt that at that time the parent would have a positive response to treatment, as the parent appeared committed to changing her relationship with her child. The clinician stated, " mom is committed to changing her relationship with child and is looking for concrete ideas of working with child".

The second session was held a week and a half later. The clinician noted that the second session had gone very well. The clinician observed that the parent was

responsive and wanted to participate. Although the parent and clinician had experienced some minor difficulties in communicating with each other, the clinician thought that rapport was continuing to be built. The clinician noticed that there was some improvement in the parent's behaviour when interacting with the child and commented that the parent would have a positive response to treatment as "mom is really trying to use the skills being demonstrated". The clinician continued to be sensitive and supportive to the parent.

The third session was held one month after the second session. The clinician reported in her journal that the third session went fairly well despite the parent being tired and not feeling well. Overall, the clinician observed that the parent responded well and engaged in the therapy. The clinician felt that rapport was good; however, she thought that the parent was having some difficulties with trust in the therapeutic relationship. The clinician noticed some more improvements in the parent's behaviour compared to previous sessions. The clinician stated that, " there was only three times that mom took toys away from child which disrupted the play". The clinician was sensitive to the parent's medical needs and acknowledged the parent's feelings but had difficulties following her conversations, which were frequently off topic. This session lasted two hours, significantly longer than the usual hour session. The clinician thought that the parent was having a positive response to therapy but stated that "mom reported difficulties with the homework and it appears that she is not doing the homework".

The fourth session was held one week after the third session. The clinician reported that session four went very well despite the parent was not feeling well and

wanted to get the session over with quickly. Having the child stay in the room during the feedback session continued to be a challenge for the clinician. The supervisor suggested that an egg timer be used to provide structure for the child and keep her in the room for a set number of minutes. In this session, the child did stay in the room for the entire session. During session four, the parent was short with the clinician and the clinician stated, "she challenged me in that she said I was not understanding what she was saying". This difficulty in communication was addressed and resolved and the session was able to continue. According to the clinician's journal, rapport in the relationship was continuing to be built and the relationship was perceived as growing stronger. The clinician continued to be supportive to the parent regarding health issues and also offered the parent support with issues regarding her son's school. Regarding improvements, the clinician noted, "they stayed focused on one task for the whole ten minutes. Child was less hyper and had a lot more positive interactions with mom".

Session five was held one week after session four. The clinician noted that session five went well but was very short as the child had a doctor's appointment. The parent looked at her watch frequently, was preoccupied during the session, and was in a rush to finish the session. After this session, the clinician felt that the parent did have trust in the relationship and in the purpose of therapy. The clinician noted more improvement in the parent's behaviours and commented, "the play is focused on one task and is not scattered from toy to toy. However she also commented that "mom is still missing the signaling with [child's name]. There is no engagement from child to me and more eye contact [between parent and child]". She also stated that

the parent would have a good response to treatment, as the parent "really wants her and [child's name] relationship to be different".

The last session, completed three weeks after session five, was an educational session. In this educational session, the parent-clinician conversation revolved around providing a secure base from which the child can explore and a safe haven for the child to return to (Cooper et al., 1998). Although the parent liked the diagram that the clinician presented, the clinician noted that she tended to deny that this information pertained to her and her child. The clinician stated, "mom reported that child had a lot of "babying" from past foster parents and that she needs to do things for herself now." After the clinician presented information to the parent, the parent justified her actions and appeared to indicate that she did not need to change her parenting behaviour but rather that the child needed to adapt. The clinician indicated in her journal that she felt good after presenting the parent with information but felt that the parent "did not fully understand the importance of attachment work". In summary, the therapeutic processes that emerged from the clinician's journal included the strength of the therapeutic relationship and specific techniques of treatment such as addressing parent's responses and behaviours to treatment, timing, length, and number of sessions, and the presence of the child in the room.

While learning and implementing MIG, the clinician experienced three learning processes. The first theme concerned learning to acknowledge and manage her emotional responses. After most of the sessions, particularly the sessions in which the parent had difficulty focusing or staying on track, the clinician felt

emotionally and physically drained and commented, "I would have liked to brief [*sic*] the session with someone and discuss the concerns I had and that mom had".

The second learning process was the clinician's ability to objectively identify which of her own skills were weak or lacking, that could be contributing to the outcome of the treatment. For instance, the clinician felt that she needed more knowledge in the area of psychological projection, and skill in articulating this concept to the parent. Using the child's name when speaking about the child during the feedback sessions is important for both the clinician and the parent. In the second session, the clinician noticed that she was not using the child's name enough nor was she reminding the parent to do so. Redirecting the parent to stay focused and on topic was a particular challenge that the clinician frequently identified. The clinician felt that it was important to learn more about medications and genetic based disorders, issues that the parent focused on in the third session. Lastly, the clinician felt that she did not have enough knowledge regarding the parent's cultural background, the religious ceremonies that she performs, and how this affects the family's home environment. In knowing which of her skills were under-developed, the clinician was able to identify her limits of competence and monitor her ability to competently and safely deliver MIG to clients. The clinician recognized that the dynamics of the parent-child dyad were complex and knew when to ask for help from Dr. Hardy and/or Dr. Vellet.

The last learning process was the clinician's ability to identify some changes that she could make for the next session to be more effective. In the first session, the clinician wanted to "go over Watch Wait and Wonder to make sure mom

understands what the concepts mean" and she wanted to call the parent mid-week to see how this technique was working for the family. The clinician noted that for the third session, she wanted to identify and discuss parent and child roles with the parent, and involve the child in the feedback sessions. Changes for the fourth session included keeping the parent and child focused and on track, keeping the child in the room during the feedback session, and helping the parent connect her behaviour to the relationship with her child. In the last two MIG feedback sessions, the clinician did not identify many changes for the upcoming sessions as she was waiting to receive feedback from Dr. Vellet regarding some significant behaviours exhibited by the parent during the parent-child play sessions. One change she wanted to implement was to engage the parent more during the feedback sessions. In summary, three learning processes emerged from the clinician's journal. These three themes related to the clinician's learning to manage her emotional responses, identify clinical skills that were weak or lacking, and identify changes to be made for the next session.

Post-treatment Phase

Client and clinical ratings of improvement. At the end of the last MIG session, the parent rated her level of improvement regarding changing parental behaviours as 4 on a 5-point scale, "somewhat improved". When asked why she made this rating, she responded, "I looked at some things differently – mostly around time and attention". The clinician, when asked to rate the parent's level of improvement, made a rating of 3 on a 5-point scale, "no improvement" in changing parenting behaviours. The clinician commented, "some progress was made, however the child

is still displaying concerning behaviours". This slight discrepancy between the parent and clinician ratings demonstrated the subjective nature of the construct of improvement and varying meanings of success.

Post-treatment client responses. After rating the level of improvement she felt she achieved, the parent responded to questions about the clinician and the treatment. The parent felt that the clinician did a good job administering the treatment but felt that the clinician was at times too "textbook" and more experience would have made understanding attachment easier. The parent found the homework assignments were "excellent" and "very useful" but felt that more handouts were needed. The parent had reported noticing some changes and improvements in her daughter's behaviour by the third session. She noted that there was "more openness – more willing to let me help her". Despite these noted changes in her child's behaviour, the parent felt that the treatment did not completely work for her family. In terms of whether she felt that the treatment worked, she commented, "I think it did and it did not. Adoption issues, grief, and other things can get in the way...harder to do with illness".

Post-treatment disrupted communication ratings. For the last parent-child play session, the supervisor rated the level of disrupted communication as 5 or 6 whereas the team's rating was 4 or 5 on the 7-point AMBIANCE scale. After discussion of the discrepancy, a rating of 5 was agreed upon. Overall, both the clinical team and the supervisor agreed that the level of disrupted communication was 2 on the modified 3-point scale, that is, parent might benefit from treatment. The

pre- and post-treatment modified AMBIANCE ratings suggest that little change occurred in the parent's behaviours.

Post-Supervision Phase

Supervisor's thoughts and reflections. The supervising psychologist had much experience supervising other groups learning MIG and found the experience with this clinical team to be positive. The audioconferences were useful but the supervisor reported that she would have found face-to-face or videoconference sessions to be more beneficial for a number of reasons. For instance, she found that her ability to supervise the team was not as rich as if she had been present in person or via videoconference. She stated:

> Watching the videotapes of the Adult Attachment Interview or the parent-child play session can activate one's attachment system and by being able to see the team I can experience the team's emotions and reactions to watching the videotapes and would then address this experience with the team.

She also felt that the audioconference sessions did not provide her with as much opportunity to provide emotional support to the treating clinician as she would have liked, although she was able to speak with the clinician over the phone to give one on one support. As well, the long distance supervision made it difficult for her to have hands-on involvement in such things as initial assessment. It was hard for her to get a complete sense of the complexity of the case until after treatment began and the parent's attachment system became activated. She commented, "we didn't identify how significant mom's mental health difficulties were until we began activating her attachment system". Had she been available to the team in person,

the supervisor thought that she could have tracked the case better and would have recommended stopping treatment earlier. She stated that, "ideally, the treatment would have been stopped and the parent referred to personal counseling".

The limitations of the audioconference and supervision was just one of several challenges the supervisor faced. Other challenges included not having enough cases to supervise, as only one client was receiving treatment, and thus not enough experience for the other clinicians on the team. The supervisor stated that if more families received treatment, more questions and learning experiences would have been presented to the team and the learning environment would have been richer. Despite several delays in moving forward with the project, the clinical team did not give up or quit. However, the supervisor sensed that there were times that the team became discouraged. She also noticed that some of the team members may not have been supported by their agencies or were feeling pressured by their agency to move forward more quickly.

The supervisor commented that the team members were "enthusiastic, committed, and had considerable experience". Regarding the preparedness of the team, the supervisor felt that the information the team had was probably adequate to get going but having more families in treatment would have enhanced the learning process and made the learning experience more interactive. Having gone through a similar process of learning MIG herself, the supervisor noted that she had provided the team with as much information up front as she could, information that her own team had learned over time. In comparison to other groups that she supervised, the Prince George team was similar in terms of level of enthusiasm and commitment.

The main difference was that the Prince George team was isolated both geographically and professionally. In comparison to teams from larger communities, the supervisor noticed that the Prince George team had access to fewer resources (e.g., adult mental health therapists with expertise in attachment). In addition, she felt that the attachment network being developed to help support one another and share information was not as broad as in other communities. She also commented that paraprofessionals learning and implementing MIG in smaller communities might run the risk of working outside their area of expertise. She stated:

> There may be a tendency to continue on with a case and provide some kind of support when what would be better would be to stop and refer to someone else for substance abuse or counseling. The risk is to push ahead and try to do the best you can because you happen to be a bit of a generalist in a small community – a jack of all trades and unfortunately with attachment work and more specifically disorganized [attachment], the intervention can be damaging, unbeknownst to yourself.

When asked how a clinician's academic and work experience influence the outcome of MIG, Dr. Vellet reported that she thinks that people who have a good working knowledge in attachment and are well trained in MIG are quite effective in bringing about some behavioural changes in the parent. However, she also stated that it is very important to have therapeutic skills to make a case conceptualization and be able to help parents make the connections between early childhood experiences, the way they parent, and their children's behaviours. A case conceptualization includes a description of a parent's overt problems, a hypothesis

about what drives and maintains the overt problems, and a plan for treatment (Kamphaus & Frick, 1996). Based on her own experiences, Dr. Vellet stated that it is the clinician's ability to bring about the parent's conscious awareness of his/her internal working model that makes the behavioural changes sustainable over the long-term. Internal working models of attachment are "mental representations of childhood attachment experiences, which become increasingly crystallized into adolescence and adulthood" (Maier, Bernier, Pekrun, Zimmerman, & Grossman, 2004, p. 180). As well, Dr. Vellet believed that every clinician should be interviewed using the Adult Attachment Interview (AAI) as it helps the clinician become more aware of his/her own attachment history and helps the clinician understand what the parent experiences in treatment. The AAI is a measure used to assess the attachment styles in adults (George, Kaplan, & Main, 1996). Dr. Vellet reported that this level of awareness helps in situations when the parent becomes disorganizing for the clinician. If the clinician has any unresolved attachment issues, a disorganizing parent can become very overwhelming to the clinician. In Dr. Vellet's opinion, academic experience is less important than clinical practical experience in bringing about behavioural changes.

The supervisor was asked what a successful treatment means to her and what a successful treatment looks like. She replied, "it can take different forms but overall a successful outcome is one in which we see some sort of shift- more in the parent's understanding, both in thinking and behaviour. They start to make connections". Sometimes there may be a change in behaviour but not in the parent's internal working model of relationships, which still may occur but later on.

Often, improvements in the parent-child dyad are seen and the parent may pull in additional outside support and may be open to seek counseling for self because he/she wants to parent differently than the way he/she was parented. Dr. Vellet found that despite the complex nature of the present case, it was a fantastic teaching case because it was a very good example of disorganized attachment and the team would definitely know for next time what disorganized attachment looks like. However, she also stated, "it is very difficult to learn a new intervention when there is such a complex mother-child dyad because it can be very challenging to create a holding space for the dyad while learning new techniques, learning the recording equipment, and exploring the learning process".

When asked what type of person responds well to attachment-relevant interventions such as MIG, Dr. Vellet reported that she has found that treatment can produce a shift in the internal working model across a broad range of parents. Dr. Vellet found that parents receiving this type of treatment do not need to be psychologically sophisticated. In fact, cognitively impaired adults respond quite well behaviourally even though they may have some difficulty understanding their own internal working model. Dr. Vellet believed that one of the most important indicators that a person will respond well to MIG is readiness for change. She commented that parents need to be very motivated to change; that is, parents must be in the action phase of the stages of change. Parents who are successful in changing their behaviour must want to parent differently than they were parented and differently than they are currently parenting. Dr. Vellet believes that others, including Dr.

Benoit, think that a strong and trusting therapeutic relationship is the most important predictor of a successful treatment.

Treating clinician's thoughts and reflections. The clinician found the experience of learning and implementing MIG to be very interesting and, compared to the MIG workshops, a much more practical experience. The clinician felt that academically, understanding the attachment literature and research as well as having knowledge pertaining to child development was helpful in learning and implementing MIG. In addition, the she felt that her work experience influenced her ability to administer MIG. She stated, "just working with the parent education programs for so long that I knew a lot of the background on discipline, sleeping, and eating problems. So that helped me tremendously and then just working with families in general helped me to know how to build rapport and be strength based and supportive". However, the clinician believed that when doing attachment work, it is important to be very knowledgeable about the attachment literature.

In the clinician's opinion, a successful treatment is one in which "the family thinks that something has changed or that something works better for them…". Commenting on what she thought success meant to the parent, the clinician stated, "I think she wanted the treatment to change her child and for the child to be different, and to have a really good relationship with her child". Because the parent reported that the treatment helped her think in a different way and do some things differently, the clinician felt that the treatment had been successful.

The clinician stated that there were several parent and clinician factors that contributed to the outcome that the team observed. One parent factor was that the

parent had some unresolved attachment issues that surfaced during treatment. The clinician felt that these issues needed to be addressed before trying to work on the relationship with her child. In addition, the clinician did not feel that the parent was ready to make changes in the way she parented. The clinician thought that having a more experienced clinician to implement MIG, having someone with more experience with mental health issues, or having someone with the expertise to do one-on-one counseling with the parent could have potentially contributed to a more positive outcome. The clinician felt that being open-minded, having the ability to gain insight, wanting to work on the parent-child relationship, and wanting to parent differently were characteristics to look for when recommending MIG to families.

The clinician commented that the therapeutic relationship with the parent was good because the parent was open and honest about sharing her emotions and her personal history and continued to participate in the sessions. Being supportive, making recommendations, and really listening to what the parent was saying were things that the clinician felt contributed to the good relationship.

The clinician found the audioconference sessions with Dr. Vellet to be excellent and very helpful. The clinician felt that the supervisor had a huge impact on her experience of learning to administer MIG. She noted that the supervisor provided her with lots of guidance and resources to use, and was very supportive through the whole process. The supervisor and the clinician communicated via email and telephone before and after the scheduled audioconference session time. Regarding the feedback, the clinician stated, "it was good, really good and every time she would give feedback and then next week I would give the feedback to the parent and

it was good, it was right on target". However, emailing Dr. Vellet directly and having immediate feedback via telephone from Dr. Vellet after a MIG session might have helped the clinician better prepare for the next session.

The clinician found that the readings and the training are great for learning MIG but it was the applied hands on experience that really solidified her understanding and knowledge of how to implement MIG. More practice and experience were two things that the clinician thought could make her delivery of MIG more successful.

Observing clinician's thoughts and reflections. The observing clinician in this study found the experience of learning MIG and observing the treating clinician to be a very valuable experience, although it took longer than expected. Although she did not provide treatment herself, the observing clinician felt that educational background and the experience of working with families made her more informed while learning MIG.

The observing clinician described a successful treatment as "engaging a person well enough that the individual will seek the necessary help needed and includes having a person who is willing to work, developing a therapeutic alliance with the family, and having a mutual understanding of the problem". This clinician felt that the treatment was successful in this case because the parent followed through with sessions, was receptive to information, and left the treatment with enough insight to hopefully seek out further help.

The audioconference supervision exceeded the observing clinician's expectations; she thought the sessions were really wonderful. The clinician was very

impressed by the expertise that the supervisor had in the area of attachment and found her clinical direction, feedback, and suggestions to be very helpful. In this clinician's opinion, having the supervisor present and having more clients involved would have made the learning process easier and more useful. The clinician also felt that having a supervised role-playing practice for each MIG session would have been very helpful in addressing issues that may arise when implementing MIG with a parent.

The observing clinician felt that other northern, rural and/or remote communities beginning to learn MIG may want to develop a framework that identifies best practices guidelines, have a central location to access support and "how-to" information regarding techniques of MIG, and find the best or ideal setting for treatment. She also felt that thought must be given to building in follow-up services for the family and addressing the need for culturally competent services, as these tend not to be addressed.

CHAPTER FIVE: INTEGRATIVE SUMMARY

Integrative Summary of the Case

Over the last three years, the clinical team involved in the MIG project worked hard to learn MIG and more recently, one clinician provided MIG to a parent. From their academic and work experiences, the clinicians that participated in this thesis had theoretical and practical experience that was relevant to the area of attachment. Both clinicians work with children, parents, and families and see the importance of attachment interventions in the population of parents with whom they work. After reviewing the initial assessment play session, the team and Dr. Vellet determined that the parent was displaying disrupted affective communication errors when interacting with her child and would benefit from treatment. Early in treatment, the parent was able to articulate some goals for treatment but at that time, did not fully understand how parenting styles influence a child's behaviour. At that time, the parent felt she was motivated to begin making the necessary parenting changes that were recommended to her. The clinician, on the other hand, sensed that the parent was not ready to change at this early stage in treatment. The clinician felt that the relationship with the parent was good.

As treatment with the parent and supervision of the teams' learning of MIG continued, a number of questions or comments by the clinician, Dr. Hardy, and the team were posed to Dr. Vellet. The clinician primarily asked questions pertaining to techniques of the treatment. Dr. Hardy commented on the emotional responses of the team as they watched videotape of the parent and the team asked for advice regarding the development of an attachment network. While reflecting on the MIG

sessions with the parent, the clinician described therapeutic and learning processes such as providing support to the parent and being able to manage her own emotional responses.

At the end of treatment, the parent felt that she had somewhat improved her parenting behaviours while the clinician felt that overall, she did not improve her parenting behaviours. The team and Dr. Vellet concurred with the clinician's rating when they submitted their rating of level of disrupted communication. The parent felt that the clinician did a good job of implementing MIG, but surprisingly acknowledged that treatment did not fully work for her and her family.

After supervision of MIG had concluded, the supervisor and the clinicians offered thoughts and reflections to questions concerning supervision the experience of learning and implementing MIG with a parent. The supervisor found the team to be enthusiastic and motivated but faced many challenges specific to the parent-child dyad and to being in a northern community. The clinicians found the experience of being supervised while learning MIG to be excellent and helpful in making this a more practical experience.

Thematic Analysis

The generic model of psychotherapy posits three main components of psychotherapy: input, process, and output (Orlinsky et al., 1994). In the generic model, the input focuses on the pre-treatment characteristics of the client and clinician within the context in which therapy occurs. The therapeutic process focuses on the characteristics of therapy and the interrelations between these characteristics. Therapeutic processes include such things as the therapeutic

contract and treatment model, the therapeutic operations, and the therapeutic bond. The output focuses primarily on treatment outcome and includes the client's post-session and post-treatment outcome and the client's current psychological functioning and life situation. As the research for this thesis revolved around the implementation of a clinical treatment, the integration of results and emerging themes are organized using a similar but more simplistic model (see Figure 1, p. 64). This model was used to organize the key themes that emerged from analysis of the parent and clinician characteristics, the treatment setting, the therapeutic and learning processes, the parent's outcome and the team's learning outcomes. In addition, this model was used to illustrate how the components of psychotherapy and learning are integrated.

Input

The input component of therapy describes the characteristics of the parent and the clinician within the treatment setting. The goal is to understand how parent and clinician characteristics might be linked to therapeutic and learning processes.

Treatment setting. Dr. Vellet and the clinical team formed the context in which learning MIG and therapy unfolded. In addition to providing supervision to the team as they learned MIG, Dr. Vellet provided the team with resources and the treating clinician with knowledge and emotional support. Two themes regarding the supervisor's role that emerged from the data was her availability to the team and involvement in the case. Given the complexity of the case, Dr. Vellet felt that being available for supervision sessions via videoconference or being personally present for the sessions would have been more helpful than the audioconferences that were

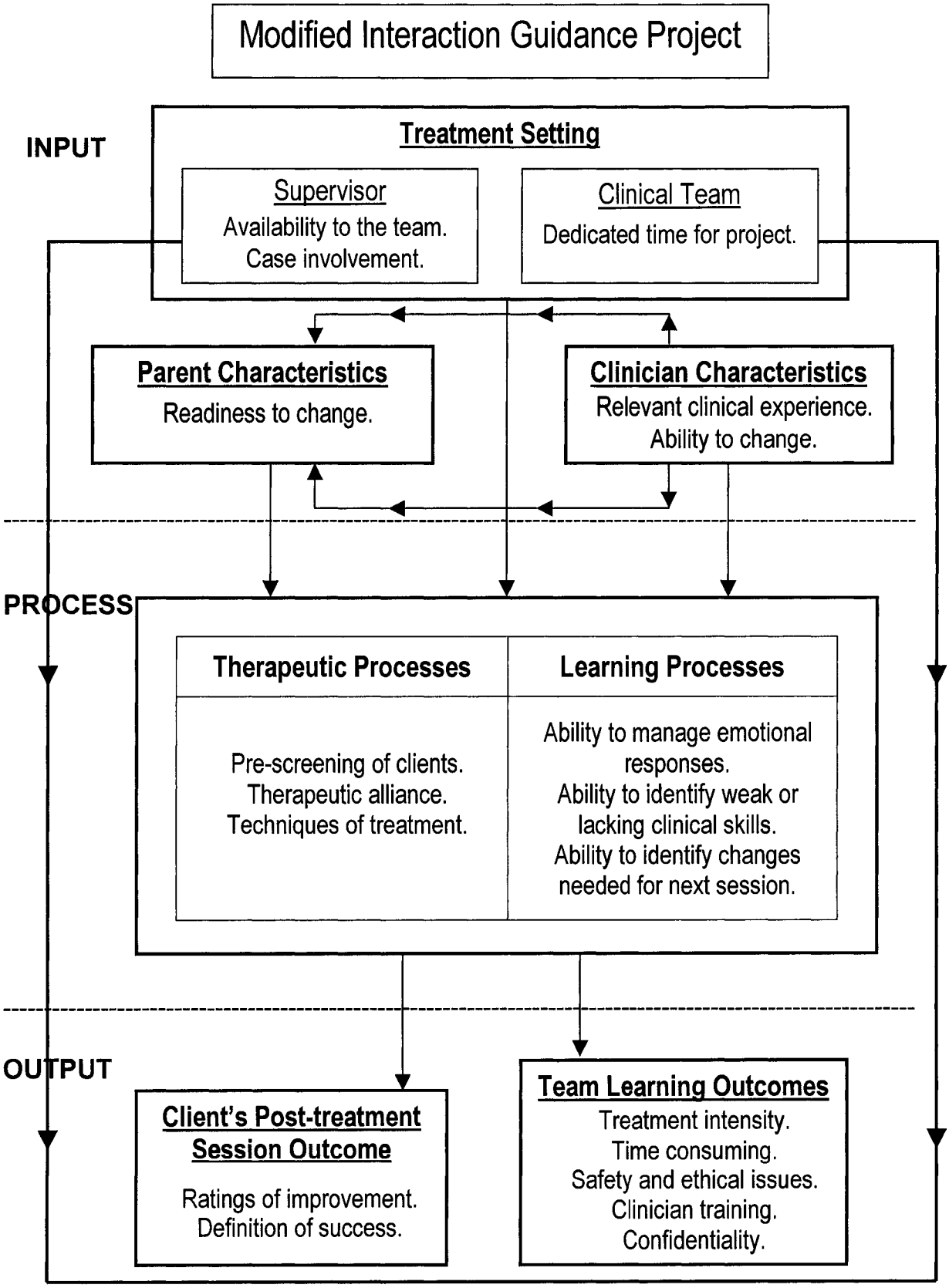

Figure 1. The generic model of psychotherapy modified for MIG.

used. That is, providing emotional support to the team and the treating clinician would have been easier and the content of the discussions more rich. As the budget for the team's project would not allow for Dr. Vellet to personally attend meetings or to hold videoconference supervision sessions, audioconferences were financially the only option open to the team. Dr. Vellet found it difficult to have hands-on involvement in some aspects of client care such as during the initial assessment phase when the parent was first selected as a learning case. If Dr. Vellet had been more involved in the initial assessment phase she would have cued the team to the possibility that the parent was not an appropriate learning case. Although unable to meet in person with the team for supervision sessions, connecting with the treating clinician immediately after each MIG session to debrief with the clinician may have provided an alternative solution to this problem. The clinician would still have the session fresh in her mind and could have provided enough detail of the session, enabling Dr. Vellet to recognize the complexity and problematic nature of the parent's response to treatment.

The key theme regarding team characteristics that emerged is the lack of time that team members were able to dedicate to the project. As all the team members are local professionals with very busy work schedules, some had difficulties finding time to attend meetings or audioconference supervision sessions and consequently were unable to commit to taking on clients. As only one team member was able to commit to taking on a client, the learning experience during supervision was not as interactive or rich as it might have been.

Parent characteristics. The parent in this project, a mother, received MIG treatment over a period of three months. One key theme regarding parent characteristics that emerged from the data was the construct of readiness to change. At pre-treatment, the parent stated that she was motivated to make the recommended parenting behaviour changes. The clinician, on the other hand, did not feel that the parent was ready to change and indicated, at pre-treatment, that the parent was currently in the contemplation stage of change. The characteristics of the contemplation phase as pertaining to attachment may include such things as the parent feeling that he/she is ready to make some parenting changes in the near future and being willing to listen to advice regarding attachment issues with his/her child. The parent involved in this project did portray these characteristics; however, she did not seem ready to make

a commitment to change her behaviour nor did she actively take steps to do so, characteristics typical of the preparation and action stages of change, respectively (Prochaska, 2000).

The parent appeared committed to treatment in the sense that she continued coming to the sessions. However, based on the length of time between sessions it was quite clear that she had difficulties committing to a weekly schedule. Over the course of treatment, the parent seemed to gain increased awareness of some of the issues she and the clinician discussed in that behaviourally, she made a few changes. However, the clinician observed that the parent had difficulties connecting her early childhood experiences and the parenting she received to her daughter's

difficulties, and tended to explain her actions in non-relational terms when presented with information or feedback from the clinician.

The fact that the parent did not complete the homework assignments was an indication that the parent was not at a stage of change that was conducive to a successful treatment. The supervisor, the team, and the clinician sensed that the behavioural changes made by the parent were not internalized. Furthermore, they did not see sufficient behavioural changes to warrant a non-disrupted communication rating post-treatment. It seems that for MIG, as for other treatments, the client needs to be in the action stage of change to experience success in treatment (Prochaska, 2000).

Clinician characteristics. From academic and work experiences, the treating clinician in this project had theoretical and practical training in topics relevant to disorganized attachment. One key theme regarding clinician characteristics that emerged from the data was the importance of relevant clinical experience. According to Dr. Vellet, paraprofessionals who are knowledgeable in the area of attachment and are well trained in MIG can quite effectively help parents make behavioural changes. She stated that being able to create a case conceptualization is a key skill for promoting behaviour change. The clinician can convey the case conceptualization to the parent which then enables the parent to make cognitive changes regarding the way he/she thinks about the parent-child relationship and his/her parenting behaviours. A second key theme regarding clinician characteristics that emerged from the data was the ability of the clinician to learn and adapt. Over the course of providing treatment to the parent, the clinician was able to change and

adapt her own behaviour in response to feedback from the supervisor and the parent and recognize her own competencies and limitations.

Therapeutic Processes

The therapeutic processes describe what occurred between the parent and clinician during MIG sessions. Three themes regarding the therapeutic processes were identified.

Pre-screening. One key theme regarding therapeutic processes that emerged from the data was pre-screening of clients. Before choosing a parent suitable for the MIG project, a number of inclusion/exclusion criteria needed to be met. Although the parent met these extensive criteria and was recommended for MIG, the complex nature of the parent-child dyad made it inappropriate as a learning case in some ways. Dr. Vellet had commented that this would have been a very complex case for even the most experienced clinician working in the area of attachment. Although the team and the clinician learned firsthand what disorganized attachment looked like, it was very difficult for the clinician to learn the techniques of treatment while working with such complex clinical issues. It would be helpful to have a less vulnerable parent-child dyad to work with while learning MIG. One strategy to address this problem might be to include more sophisticated assessment measures prior to commencing treatment. A problem with this strategy is that the clinical team in this study did not have access to a diagnostician who could make mental health assessments. However, having the supervisor more involved during the assessment phase would provide the supervisor with the opportunity to evaluate the parent's suitability as a learning case.

Therapeutic bond. A second key theme regarding therapeutic processes that emerged from the data was the therapeutic bond. A very important component of any treatment is the relationship between the clinician and the parent. It has been well documented that a positive and productive therapeutic alliance can be highly predictive of parent adherence and treatment outcome (e.g., Greenberg, Elliot & Lietaer, 1994). Elements of a strong therapeutic relationship include the clinician and parent having shared goals for therapy. The clinician contributes to the relationship by providing respect, acceptance, objectivity, attentiveness, insightfulness, empathy, and emotional security, all of which provide the foundation for building trust and is the context for change (Kolden, 1996). The clinician believed that her work experience enabled her to treat parents with respect, empathy, sensitivity, and compassion. As well, the clinician was an active listener and appeared to be non-judgmental and objective. Throughout treatment, the clinician reported that in her opinion, the therapeutic relationship with the parent was good; trust was continuing to be built and the relationship was continually growing stronger. Although only subjective opinions regarding the therapeutic bond were captured in the data, trust and rapport must have existed between the clinician and the parent, in that the parent continued to attend sessions and was comfortable enough to be open and honest with the clinician about very personal information.

Techniques of treatment. A third key theme regarding therapeutic processes that emerged from the data was the techniques of treatment. While providing treatment to the parent, the clinician worked diligently to understand and master the techniques of MIG. Having never provided this treatment to a parent before it was

not surprising that the clinician had many questions for the supervisor as treatment progressed. A number of technical aspects of treatment were identified and included questions regarding intake protocol, parent's responses and behaviours to treatment, audiovisual equipment and videotaping the sessions, timing, length, and number of sessions, and presence of the child in the room during feedback sessions.

Questions regarding the technical aspects of MIG began with the initial intake. As the clinician did not have formal intake protocol to follow she consulted with Dr. Hardy and Dr. Vellet regarding what questions to ask the parent. The clinician consulted with the supervisor regarding how to address some of the parent's responses and behaviours to treatment. In the first session, the clinician had questions with the supervisor as she was challenged by the parent's discomfort in being videotaped. In addition, questions regarding the audiovisual equipment and how to address minor videotaping glitches were also posed.

Other technical aspects of treatment that emerged were regarding the timing, length, and number of sessions. For example, Dr. Vellet commented that scheduling consecutive weekly sessions is best. In this case, there were sometimes large gaps of time between sessions with the parent. The parent's difficulty in attending regular weekly meetings may have been linked to being in the contemplation stage of change. As well, having too much time between meetings may not have allowed for the parent to receive the full benefit of the feedback sessions and may have adversely impacted the treatment outcome. In MIG, a typical weekly session should normally take approximately 1 hour. This time would include a 10-minute parent-

child play session with 50 minutes remaining to review the videotaped clips and provide the parent with feedback. The clinician had noted that some of the sessions had been extended to about two hours as the parent had difficulties staying focused and on-topic. These lengthy sessions were emotionally and physically tiring for the clinician and most likely for the parent too. Once again, this response to treatment may indicate that the parent was not actively ready to change her parenting behaviour at that time and had unresolved personal issues. In the journal, the clinician had commented that she needed more skill in keeping the parent focused during the feedback sessions. The clinician's inexperience in delivering MIG may also have contributed to the lengthy sessions. Regarding the number of MIG sessions that the parent received, only five MIG sessions were completed. The literature on MIG suggest that 6 to 8 sessions, and possibly more, would be most beneficial for the parent (Benoit et al., 2001). As this parent appeared to have had unresolved personal issues that were interfering with the treatment, Dr. Vellet recommended that treatment be stopped at the end of the fifth session.

A last technical aspect that emerged was regarding the presence of the child in the room during the feedback session. A challenge that the clinician experienced while providing MIG to the parent was keeping the child in the room while reviewing the videotape and providing feedback. In the first feedback session, it was observed that the child became aggressive and distressed while watching the videotape of the play session and wanted to leave the room. This problem was discussed with Dr. Vellet and the goal was to keep the child in the room for a certain amount of time during the feedback session. Although the clinician and the team recognized that the

child's behaviour was an indication that something was occurring, the meaning and importance of the child's behaviour was not realized until after treatment was completed. That is, the child was likely responding to the mom's distress and discomfort during the feedback session. A more experienced clinician might have recognized the reason for this behaviour and addressed the issue "in the moment".

Learning Processes

The learning processes describe how and what the clinician learned as she was implementing MIG with the parent. Given that this was the clinician's very first experience administering MIG to a client, it was expected that the clinician would experience some difficulties with the techniques of treatment and the more challenging aspects of therapy. For the clinician, the experience of providing therapy to a parent was a learning process. One theme that emerged was that the clinician discovered throughout treatment that some of her therapeutic skills were under-developed. These skills included understanding and articulating the concept of psychological projection and case conceptualization, that is, helping the parent understand the connections between the way he/she was parented and the way he/she parents currently, and how this parenting style is affecting the child's behaviour. A second theme that emerged was that the clinician learned to manage her emotional responses. Having a clinician that is accepting, nonjudgmental, objective, empathetic, and professional is a key element of a strong therapeutic relationship (Orlinsky et al., 1994). The third theme that emerged was that the clinician learned to identify changes that needed to be made for subsequent MIG sessions. That is, the clinician was able to recognize what was not working well in

therapy and addressed these issues to bring about a more positive outcome for the parent. The clinician's ability to learn these skills in response to feedback from the supervisor and parent is a reflection of the clinician's characteristics and her abilities as a clinician.

Output

The output component of therapy describes the parent's outcome and the learning experiences of the team once treatment was completed.

Client's post-treatment outcome. At the end of the last session, there was a slight discrepancy between the parent's and the clinician's rating of improvement. The parent felt that she had somewhat improved regarding changing her parenting behaviours while the clinician felt that she had not improved at all. Similarly, the team and the supervisor found that although the parent had made some improvements in the way she parented, these changes were not enough to warrant a change in the AMBIANCE or modified AMBIANCE score.

When evaluating the outcome of a treatment, the meaning of a successful outcome needed to be explored and a theme that emerged from this data was the subjectivity of the meaning of success. To Dr. Vellet, a successful outcome implied a shift in a parent's thinking and behaviour. To the treating clinician, a treatment outcome was successful if the family thought that something had changed or was working better, while the observing clinician felt that a treatment was successful if it had engaged the parent enough that he/she sought needed help. In the first session, the parent stated that she would know treatment was working if her child was more responsive to her. In the last session, the parent felt that while she looked at some

things differently and noticed some positive changes in her child's behaviour, the treatment was not entirely successful for her family. Surprisingly, the parent recognized that many things in her life were making it difficult for her to focus and commit fully to this treatment. Thus, the parent was indirectly acknowledging that she was not prepared to take action. The variations in the definition of success among the participants reflect the subjective nature of this construct. Knowing how the parent and clinician view success will help tailor the goals and direction of the intervention so that the parent and clinician are more likely to work together towards the same outcome. A problem with some definitions of success is that desired outcomes may not reflect behavioural or cognitive changes and may not benefit the child or the parent-child relationship in any way.

Learning outcomes. Although only one clinician was able to provide treatment to one parent during supervision, the team learned many things through this process. One theme regarding learning outcomes that emerged from the data was that the team learned that attachment work is emotionally intense and impacts both the clinician and the parent. A second theme that emerged was that the team discovered that learning and providing treatment to parents requires a significant amount of time. To address this issue, clinicians needed to be prepared to set aside dedicated time to devote to learning MIG. A third theme that emerged was regarding the safety and ethical issues that clinicians need to take into consideration when learning and providing MIG. For instance, having the tools to properly select and prescreen parents is of utmost importance. Also, parents that are chosen to receive treatment need to be mentally and emotionally prepared to engage in therapy. As

clinicians learn MIG, one of the main responsibilities of the supervisor is to ensure the safety of the parent. For the supervisor, one way of ensuring the parent's safety is to be highly involved in all aspects of each case. A fourth theme that emerged was regarding the careful selection and training of clinicians. To ensure parent safety, clinicians need to be knowledgeable in the area of attachment and possess the therapeutic skills to successfully engage with and support their parents. As well, clinicians must be able to identify their competencies and limitations and recognize when they are outside their area of expertise so as to avoid doing more harm than they are doing good. A fifth theme that emerged was regarding client-clinician confidentiality. As many of the team members work with children, protecting the child is always a priority in their work. To ensure parent confidentiality, tapes must be stored in a secure location and either kept with the parent's record or destroyed after treatment ends.

CHAPTER SIX: DISCUSSION

The purpose of this case study was to document the therapeutic and learning processes that unfolded during MIG sessions and supervision as a paraprofessional, who was a non-expert in attachment, learned to administer MIG. A goal of this study was to identify and describe key clinician and parent characteristics thought to be related to the learning and therapeutic processes involved in MIG. It was not the focus of this research to measure the success of the treatment, however the clinical outcome was evaluated in order to understand the ways in which therapeutic processes of MIG influenced parental behaviour. As this was the clinician's very first time implementing MIG with a parent it was not expected that the clinician would deliver a completely successful treatment. However, the insights that were gained from the team's and clinician's learning experiences were invaluable. This thesis was the first step in a larger project documenting the learning and therapeutic processes of MIG with the goal being knowledge translation to other teams wanting to learn and provide MIG to clients. In this discussion, the research questions that were posed in this study are discussed first followed by a discussion of the limitations of the research, and suggestions for future research and future training of clinicians.

Therapeutic and Learning Processes

The primary focus of the present study was to document the therapeutic and learning processes that unfolded during MIG sessions. One therapeutic process that was identified and documented was the pre-screening of clients. The Inclusion/Exclusion Criteria Checklist used in this study to choose suitable parent-

child dyads was extensive. However, it was not realized until after a few MIG sessions had been completed that the parent was probably not the most appropriate client for a clinician to work with while she was learning MIG. The issue that emerged with the checklist was that the team could not assess many of the aspects listed on the inclusion/exclusion checklist such as depression or personality disorders. That is, the clinical team did not have access to a diagnostician who could make these assessments. This would most likely be a problem for other northern, rural and/or remote communities wanting to implement MIG with clients.

Another therapeutic process that was identified and documented was the therapeutic bond. A considerable amount of research has studied the therapeutic bond and findings indicate that the therapist's and client's contribution to the bond is significantly and positively associated with outcome of treatment (Orlinsky et al., 1994). From the treating clinician's journals, she appeared to be non-judgmental and had an empathic understanding of the parent, and also seemed friendly, supportive, accepting, and understanding towards the parent, all of which are important factors that influence the quality of the bond (Orlinsky et al.). Although the clinician did not have extensive clinical training in therapeutic relationships, it is most likely that her experiences working with families made the task of building rapport and a therapeutic bond easier, albeit not perfect. The parent's involvement and motivation to engage and cooperate in the therapeutic relationship most likely also impacted the therapeutic bond and treatment outcome, however the parent's contribution to the relationship was not well documented. The parent did divulge a considerable amount of personal information to the clinician, which suggests that

there was some trust in the relationship. The parent also picked up on the clinician's lack of experience with MIG, which may reflect that the clinician's self-confidence and persuasiveness was not always strong.

Another important therapeutic process that emerged from the clinician's journal, audioconference supervision sessions, and email communications were the therapeutic operations, or more specifically the technical aspects and procedures of MIG treatment. From the first to the very last MIG session, the treating clinician was learning to implement a treatment that was unfamiliar to her. In fact, this clinician had never done MIG, nor had she watched MIG being implemented with a client before. With each new client comes unique characteristics and distinct problems or issues. During treatment, the treating clinician found herself asking questions about videotaping procedures and how to best proceed with the sessions given some of the challenges that were experienced. It has been well documented that the techniques and procedures that a therapist uses to help induce change in a client and their skillfulness in delivering these are associated with treatment outcome (Kolden, 1996).

The timing, length, and number of sessions were other therapeutic processes that emerged during treatment. Ideally, the parent was to have 6 to 8 weekly one-hour MIG sessions. What occurred was only five MIG sessions with the length of time between some sessions being longer than one week and some sessions lasting considerably longer than the usual one hour. These were some of the challenges that the treating clinician experienced and consulted with the supervising psychologist about. It was under the advisement of Dr. Vellet that MIG

sessions be stopped early with the parent. Regarding the length of treatment duration there tends to be little consensus. For instance Orlinsky et al. (1994) state that longer treatment durations are generally associated with more positive treatment outcomes. Others like van Ijzendoorn (2003) believe that "less is more". That is, the most effective interventions use only a moderate number of sessions. This debate was not evaluated in this study but for client safety reasons, treatment was stopped early.

A last therapeutic process that was documented during treatment was the presence of the child in the room during the clinician-parent feedback sessions. In the first feedback session, the child began to act out. The clinical team realized that the child's disruptive behaviour was representative of something but in those initial MIG sessions, it was not clear how complex the dynamics of this parent-child dyad was. The clinician and supervisor devised a strategy to help keep the child in the room but it would have also been very beneficial to address the child's responses to watching the videotaped play session in the moment.

While implementing MIG with the parent, there were three main learning processes. Attachment-focused treatments are an intensely emotional experience for both the client and the clinician. The clinician learned to acknowledge and manage her own emotional responses while providing treatment to the client and after the session was over. This is an important process because the clinician does not want her own emotions and opinions to influence the way she interacts with the parent, which can have a negative impact on the parent's behaviour and thus treatment outcome. The clinician also learned to identify her own skills that were

under-developed and worked to become more knowledgeable or skilled in certain areas. Lastly, the clinician was able to identify changes that needed to be made for future sessions. These processes that the clinician learned helped her become a more skilled and competent clinician, which influences the parent's behaviour and treatment outcome.

Parent and Clinician Characteristics

The major theme that was identified about parent characteristics was readiness to change. Prochaska's (2000) stages of change are most often associated with people struggling to overcome addictions. In the Prince George Attachment Project, the focus of MIG treatment was on the reduction or elimination of disrupted parental communication errors. Essentially, MIG was developed to help parents change the way that they communicate and interact with their child, a process in which parents have to change the way they think and behave. Although the stages of change are primarily used to describe how ready an individual is to change behaviours associated with such things as drinking and smoking, the stages of change paradigm also works well for any problem requiring behavioural and/or cognitive change, like parental behaviours. It was apparent at the beginning of MIG treatment that there was a discrepancy between the parent's and clinician's perception of the parent's motivation and readiness to change. Although the parent responded at the beginning of treatment that she was motivated and ready to take the necessary steps to change her parenting behaviour, her actions throughout treatment did not portray this sentiment. As well, the ratings of disrupted communication post-treatment did not improve from the ratings at pre-treatment. In

the therapeutic processes such as therapeutic operations and therapeutic bond, patient cooperation is a requirement and a necessity for a favorable outcome (Orlinsky et al., 1994). That is, the patient must be willing to experience affective reactions to therapy, engage in self-exploration, and invest in and contribute to the therapeutic relationship (Orlinsky et al.). The client's level of cooperation is a reflection of the stage of change that he/she is in at that time. Prochaska suggests that one way in which treatment programs can be more successful in terms of reducing dropout rates, moving people to progress in therapy and after therapy, and progress from one stage of change to the next is to match the intervention to the stage of change that the individual is in at that time. That is, clients must be treated in a way that targets the stage of change that they are in and fosters progress through the stages of change. This draws heavily on the clinical skills and expertise of the clinician.

One major theme that was identified about clinician characteristics was the importance of clinical experience. In psychotherapy, the therapist's skill may be the most important component related to the success of the treatment. At the beginning of treatment, therapists must be able to construe the information that the client provides and use their practical and theoretical knowledge to create a case conceptualization about the client. From there, therapists use their expertise to create an intervention that is client specific and use their skills to develop strategies that will help clients bring about changes in themselves or their life situations (Orlinsky et al., 1994). Prochaska (2000) would further state that therapists have to know the principles and processes of change and utilize strategies to help motivate

their clients to progress through the stages of changes. In addition, therapists require a great deal of skill to contribute successfully to the therapeutic bond. They must have excellent communication contact and mutual affect with their client. That is, the therapist must have empathic understanding for the client and treat the client with warmth, acceptance, and positive regard (Orlinsky et al.).

This study has provided some insight regarding the clinical skills a paraprofessional needs to implement MIG effectively and safely. In addition, this study has also brought forth the question of what level of change do we want parents to experience during and after receiving MIG, only behavioural or cognitive-behavioural? MIG was developed to be a behavioural intervention but some question the sustainability of the change when only the parental behaviours are targeted. Instead, these individuals think that a cognitive-behavioural approach to MIG is more appropriate considering the deep-seated roots that parenting has. Besides focusing on parenting behaviours, addressing past issues of loss or trauma, and bringing awareness to a parent's internal working model of attachment may be necessary to achieve long-term change in parental behaviours. As well, this study has provided insight into how we define success or outcome and how this definition guides the treatment and influences outcome. Finally, it needs to be asked if paraprofessionals working in smaller communities can do this work effectively and safely? In this present study, it is believed that the clinician was able to implement MIG effectively and safely to the parent while under the supervision of a psychologist. More importantly, how clinical teams, organizations, and

communities support and foster a clinician's learning to achieve the level of skill to adequately implement MIG needs to be considered further and addressed.

A second key theme that was identified about clinician characteristics was the ability of the clinician to learn and adapt while implementing MIG with the parent. That is, the clinician was able to change or adapt her own behaviours in response to feedback from the supervisor and the parent. In addition, she was able to recognize her strengths, weaknesses, and limitations and consulted with the supervisor to address challenges she was experiencing. This ability to learn increased the clinician's skills and effectiveness in delivering MIG to a parent.

Limitations of the Present Study

For the present study, a case study was chosen as an appropriate strategy because the purpose of the study was to explore and describe what occurred when a paraprofessional learned to implement MIG with a client. The case study seemed like the best choice for offering a rich and in-depth look into this unique topic. Goldfried and Wolfe (1996) suggest that the case study may provide the clearest description for understanding the link between what happens in therapy and client change. Despite its advantages, the case study is not without some limitations or disadvantages. For instance, case studies are not easily replicated so the issue of reliability may be questioned. However, a number of techniques such as triangulation were used to ensure the reliability of this study. In a case study, issues of validity can also questioned. Using multiple sources of evidence and consulting with Dr. Hardy were methods used to increase the validity of this case study. Despite the advances made in research methods, a divide still exists between qualitative and

quantitative researchers. While some argue that the use of quantitative data collection methods in qualitative research is important for such things as triangulation and increasing the reliability and validity of a study, others feel that mixing methods does not reflect the philosophy of qualitative research (Nerlich, 2004). As this case study had a very small sample size, generalizations of the results to the larger population cannot be made. Although a large sample size is often the norm in quantitative research, Creswell (1998) states that in a case study, having a larger sample size compromises the richness and depth of the case and weakens the analysis of the data. Yin (1993) suggests that the statistical generalization found in quantitative research differs from the analytical generalization found in case study research. Analytical generalization refers to generalizing the results of the case to a broader theory (Yin, 1993). Another limitation of the case study is that the subjective feelings of the researcher most likely had some influence on the collection and analysis of the data, and on the conclusions that were drawn. The researcher was however cognizant and understanding of how her biases and feelings would affect this process.

Another limitation of this study was regarding some of the data collection approaches that were used. For instance, the clinical team assessed the level of disrupted communication displayed by the parent pre- and post-treatment using the AMBIANCE and modified AMBIANCE coding protocol. As there was only one parent participating in this study, the reliability and validity of the AMBIANCE and modified AMBIANCE coding protocol were not evaluated. However, the clinical team's disrupted communication scores were cross-checked with the scores of Dr. Vellet to

obtain a sense of the team's ability to use the AMBIANCE reliably. Dr. Vellet is trained in the use of AMBIANCE and is a reliable coder. Another limitation experienced with the data collection approaches was the usefulness of one of the measures. More specifically, a risk factor summary checklist had been developed but it became apparent that the information that was gathered in this checklist was not as useful as had been anticipated and was not included in the analysis. It was not realized until analysis was well under way that some of the questionnaires were not near as in-depth as they could have been. For example, a more concise set of questions addressing the parent's motivation and readiness to change should have been used. It is quite clear from the literature that the therapeutic bond is an integral component of psychotherapy; however, the responses that the parent made in the questionnaires and that the clinician made in the journal do not fully capture the quality of the therapeutic relationship. From the perspectives of both the parent and the clinician, questions addressing the clinician's and parent's contribution to the bond, and the clinician's and parent's communicative contact and affirmation should have been included. A last limitation of the data collection approaches involved the clinician and supervisor interviews. Interviews provide a rich source of data but the interviewees in this study may have interpreted the questions differently than they were intended to be. As well, the researcher's biases may have influenced the phrasing of the questions and interpretation of the responses. The researcher also did not have a lot of experience conducting interviews and found it difficult to probe the interviewee to provide more detail or clarification to the responses.

Future Research

The present study was developed as a pilot study for a larger community based project. The implications for children with disorganized attachment are life-long and continuing to do research in the areas of disorganized attachment, disrupted parental communication, and intervention and treatment is extremely important. In particular, research on implementing MIG in northern, rural and/or remote areas needs to continue. These communities face many challenges in comparison to large urban centers such as lack of funding, lack of social networks, and shortage of mental health professionals and diagnosticians. Addressing these challenges through research may shed some light on how to solve these problems. Continuing to study teams as they learning to implement MIG and following these teams as they integrate MIG into their own organizations or programs will provide more insight into the therapeutic and learning processes that occur in MIG and may provide paraprofessionals with the tools to ascertain which parents would be the best candidates for MIG.

Future Training of Clinicians

It has been established in this study that having the clinical skills to implement MIG requires relevant clinical experience. It has also been established that paraprofessionals can deliver MIG safely with adequate supervision. What is important for other clinical teams to know when trying to learn MIG is how to support the clinicians' learning process so as to maximize their effectiveness when implementing MIG to clients. Learning and implementing MIG to clients is a time-consuming endeavor and it is important for organizations to support their clinicians

and allow them the time to dedicate to learning MIG properly. Learning and implementing MIG to clients is not something a clinician can do in his/her spare time but rather needs to be part of the job description. As learning and implementing MIG is time-consuming, it is also very emotionally intensive. Providing clinicians with a social network, knowledgeable in attachment and MIG, in which they can debrief after sessions or consult with when experiencing problems or questions enhances the learning experience. It is also important that clinicians be well aware of the legal, ethical, and safety issues that arise when working with parents and children. Having supervision by someone who is an expert in attachment and in the techniques of MIG makes the learning experience richer and helps ensure the safety of the clients involved in treatment. In addition to the expertise of the supervisor, the learning experience may be more salient if the supervisor is able to teach and supervise a clinician in person or via videoconference. Having a supervisor involved in client selection and throughout the sessions provides the clinician with invaluable direction and feedback and also ensures the safety of the client. Having a supervisor, team, and organization to support and guide the learning of MIG will enable clinician to improve their skills and become more effective in providing treatment to clients.

This study accomplished understanding further the therapeutic and learning processes that unfolded as a paraprofessional, who was a non-expert in attachment, implemented MIG with a client while under the supervision of a psychologist. Further insight was gained regarding the clinician and parent characteristics that influenced the processes and outcome.

Although the Prince George Attachment Project has proceeded quite slowly, the team has shown great dedication to learning the techniques of MIG and is still continuing to learn MIG with the guidance of Dr. Vellet. This team has also established an attachment network that reaches out across northern British Columbia. It is dedicated individuals passionate about attachment issues and invested in the well-being of our children, like the ones involved in the attachment project and this study, that will have the greatest success in incorporating interventions like infant massage, WWW, and MIG into our organizations and communities. As well, it is individuals like these that will make a difference in the lives of the families that live in these communities.

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Appendix A

Inclusion/Exclusion Criteria Checklist

Complete this checklist before contacting a potential client, in order to decide whether a given client is suitable for the MIG project.

Clinician Name: _____ Date: _____

Suitable families **include** those in which:

1. A child 7 years of age or younger is suspected of having disorganized attachment relationship with the parent who would be involved in MIG treatment.

2. The parent is likely to be receptive to participating in supervision and research activities

We will **exclude** families who meet one or more of the following criteria:

3. The parent has an active file with MCFD due to child protection concerns (parents who have open file in order to receive services can be included; those in active investigation phase can not)

4. The parent has a history of violence or aggression towards the child.

5. The parent is actively engaged in addictive behaviours that diminish parenting capacity and/or the parent's ability to benefit from MIG treatment.

6. The parent is acutely psychotic

7. The parent is acutely and severely depressed

8. The parent is attending personal psychotherapy (consider whether you need to ask parent for permission to contact their therapist in order to coordinate services for the family

9. The parent is known or thought to have borderline personality disorder and if the parent's behaviour is harmful to the child

If the parent meets all inclusion criteria and none of the exclusion criteria, record the following and place this form in the client's clinical record.

This parent was referred to the MIG Project on: _____.

Clinician's Name and Signature: _____.

Clinician Information Sheet
Prince George Attachment Project

Researchers' Names:	Loriann Quinlan and Dr. Cindy Hardy
Address:	Psychology Program, UNBC, 3333 University Way, Prince George BC V2N 4Z9
Phone:	250-960-5814
Title of Project:	Implementing Modified Interaction Guidance as a Treatment for Disrupted Parental Communication in Prince George: A Case Study
Type of Project:	Graduate Thesis and Faculty Research

The purpose of this project is to document the process of learning Modified Interaction Guidance (MIG). MIG is a psychological treatment that helps parents respond more effectively to their young children. Local clinicians who work with young children and their parents will receive supervision in use of MIG from Dr. Sonya Vellet. Supervision sessions will occur in 2004 and 2005.

Potential benefits for clinicians are acquisition of new clinical skills and the opportunity to receive technical supervision from a psychologist with extensive experience in working with young children and their parents.

Potential risks for clinicians include the discomfort of having other clinicians observe and discuss videotaped records of the clinician's work, and pressures caused by the time commitment required for this work. Clinicians will be required to devote approximately two hours of record-keeping and supervision activities for each hour of service delivered to clients.

As a clinician, you were selected for inclusion in this study by virtue of your ongoing involvement in the Prince George Attachment Project. Your involvement started when you attended the workshop by Dr. Benoit, held in June 2002. Since then, you have participated in meetings and workshops focused on learning the AMBIANCE coding system and MIG treatment.

For the present study, you are being asked to participate either as a treating clinician or as an observing clinician, or as both for different clients.

As a treating clinician, you will provide MIG to two clients and receive supervision regarding your work with those clients. Videotapes of your sessions with clients will be used in research. In addition, as a treating clinician, you will be asked to complete the following measures:

- $ a questionnaire regarding your academic and work experience,
- $ a questionnaire regarding conditions at start of treatment (client's readiness for change and therapeutic alliance),
- $ pretreatment team evaluations of each client's parenting behaviours,

- risk factors checklist (one per client) based on your knowledge of your clients,
- journal of your experience of learning MIG,
- posttreatment clinical ratings of improvement, and
- an in-depth interview at the end of clinical supervision (to be audiotaped).

As an observing clinician, you will act as a partner and support person for the treating clinician, providing peer supervision and reflection to the treating clinician, assisting with videotaping, and helping clients and treating clinicians complete research-related paperwork. You will participate in supervision sessions. As an observing clinician, you will also be asked to complete the following measures:

- a questionnaire regarding your academic and work experience, and
- pretreatment team evaluations of each client's parenting behaviours.

Due to the collaborative and team-based nature of this project, it is not possible to offer you complete privacy. During supervision sessions, other clinical team members will observe your videotaped interactions with clients and will hear your discussion of your learning process. These videotaped interactions will also be used for research purposes. Only Loriann Quinlan and Dr. Cindy Hardy will have access to the data you contribute in written form, in a form that identifies you. Your identity will be kept private in all written reports arising from this research.

To the extent possible given group supervision activities, your identity will be kept anonymous and all your contributions to the project will be treated confidentially. As you know there are limits on confidentiality which might require us to break confidentiality in situations in which someone (e.g., a child, a parent, or a clinician) is in imminent harm. The information collected from you will be stored in a locked cabinet in Dr. Hardy's research lab, which is always locked when unoccupied. Written data will be stored for 5 years following completion of the research report then shredded. Videotapes will be destroyed at the end of the data collection.

Your participation in this study is purely voluntary. You are free to give or withhold consent to participate in this research. If you do agree to participate, you are free to withdraw at any time without giving a reason and all information provided by you will be removed from the study. If you chose not to participate in the research or decide to withdraw after you start, you are still welcome to participate in supervision sessions with Dr. Vellet.

Research results will be shared with the clinical team in oral and written forms. The researchers will give you a copy of the written report when it is ready. If you have questions or concerns or need more information about this project, please contact Dr. Cindy Hardy at 960-5814. If you have complaints about this project, please contact UNBC's Vice President of Research at 960-5820. Attached are two copies of the consent form. Please complete the forms then return one copy to the researcher and keep the other copy along with this letter for your records.

Clinician Consent Form
Prince George Attachment Project

Please complete this form to indicate your understanding of the project and to indicate your decision regarding consenting to participate.

Do you understand that you have been asked to participate in a research study?	YES	NO
Have you read and received a copy of the attached information sheet?	YES	NO
Do you understand that your work with clients will be videotaped and used for research purposes?	YES	NO
Do you understand that the research interview will be audiotaped?	YES	NO
Do you understand that the research reports based on the information you submit will respect your privacy and maintain your anonymity?	YES	NO
Do you understand the risks and benefits of participating in this study?	YES	NO
If you chose to refuse or withdraw, you do not have to give a reason and you are welcome to participate in supervision. If you withdraw, all information you provide will be removed from the study. Do you understand that you are free to refuse to participate and/or withdraw at any time without consequence?	YES	NO
Has the issue of confidentiality been explained to you? Do you understand who will have access to the information you provide?	YES	NO

This study was explained to me by: _____.
Check one of the following to indicate your decision regarding participation:

_____I agree to participate in this study as a treating clinician.

_____I agree to participate in this study as an observing clinician.

_____I do not agree to participate in this study.

_____ _____ _____.

Name of Participant (printed) Date Signature of Participant

_____ _____ _____.

Name of Witness (printed) Date Signature of Witness

I believe the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____ _____ _____.

Name of Researcher (printed) Date Signature of Researcher

Client Information Sheet
Prince George Attachment Project

Researchers' Names:	Loriann Quinlan and Dr. Cindy Hardy
Address:	Psychology Program, UNBC, 3333 University Way, Prince George BC V2N 4Z9
Phone:	250-960-5814
Type of Project:	Graduate Thesis and Faculty Research

We are conducting a study about how therapists use a treatment that helps parents/guardians and their young children. Your therapist will receive training in the use of this treatment from an expert, Dr. Sonya Vellet from Calgary AB. You and your child are being invited to join the study as clients. If you decide to join the study, possible benefits for you are increased skills as a parent or guardian. It is also possible that your child will be happier and less stressed after treatment.

You will be asked for your consent in two steps. First, we will ask for your consent to participate in clinical and supervision procedures. If you agree, we will perform an assessment procedure. If the assessment procedure indicates that you might benefit from MIG treatment, you will then be invited to participate in research. In all cases, you have control over how much of your personal information is released to the researcher.

If you decide to join the study, you must be aware that some potential risks to you and your child might arise due to lack of privacy. We are asking you to let us videotape you interacting with your child and with your therapist. The videotapes might be viewed by other therapists and by the research team, not just your therapist. During training sessions for your therapist, we might discuss how your treatment is going. Our goal will be to help your therapist improve her treatment technique. This might lead you to feel a lack of privacy at times. Another thing you might find stressful at times is the treatment itself, because it might require you to change your parenting behaviours.

You are being invited to join this study by your therapist, who thinks the treatment might help you and your child. You are also being asked to join the study because you are a parent or guardian of one or more children 7 years of age or younger and because you do not have an active file with MCFD because of child protection concerns.

After we have done an initial assessment and only if MIG treatment is recommended, you will be invited to join the research study. Your choices are:

- **No research**. None of your personal information or videotapes will be released to the researcher and your clinician will not participate in research with reference to you.
- **Limited research**. Your clinician will have your permission to complete questionnaires and to keep a journal with reference to your treatment, but you will not be asked to complete questionnaires and none of your videotapes will be released to the researcher.
- **Full research**. You and your clinician will participate in all aspects of the research

and your videotapes may be released to researcher.

If you agree to **full** research, you will be agreeing to:

- Give permission to let the researcher view videotapes of you playing with your child,
- Give permission to let the researchers view videotapes of your therapy sessions with your therapist,
- Respond to a questionnaire regarding your expectations for treatment,
- Complete a post-treatment rating of improvement, and
- Complete a post-treatment questionnaire regarding your views of treatment.

The questionnaires and ratings will take you about two hours total, over and above the time you will spend attending therapy.

If you agree to **full or limited** research, you will be agreeing to:

- Give permission to your clinician to complete some questionnaires about your treatment progress to the researcher.
- Give permission to your clinician to keep a journal about your treatment and release that journal to the researcher.

Due to the team-based nature of the training for the therapists in this study, the researcher cannot offer you and your child complete privacy. During training sessions, clinical team members will watch your videotaped interactions with your therapist and your child. Clinical team members work at the Child Development Centre, the Northern Health Authority, and Worth Counselling and Assessment Services. Project team members include Candis Johnson, Cindy Ignas, Chantelle Wilson, Janice Butler, Shelley Anderson, Sonya Vellet, Loriann Quinlan, Dr. Cindy Hardy, and Tamara Ritchie. All of these people are health or research professionals who will protect your confidentiality and privacy. The only reason we might have to break confidentiality is if we are concerned with the immediate safety of you, your child, or your clinician.

If you agree to join the study, researchers Loriann Quinlan and Dr. Cindy Hardy will use the information you share with us in a way that protects your privacy. Your identity and that of your child will be kept private in all written reports that come out of this research.

Your identity will be kept anonymous as much as possible during the training sessions your therapist attends, but team members might see you on videotape. All your thoughts about this project will be treated confidentially and will not be shared with your therapist. Any private information released to the researcher will be stored in a locked cabinet in Dr. Hardy's research lab at UNBC. The lab is always locked when unoccupied. Written data will be stored for 5 years following completion of the research report then shredded. Videotapes will be destroyed at the end of the data collection phase of the study.

Your participation in this study is purely voluntary. You are free to give or not give consent to participate in this research. If you do agree to join the study, you are free to leave the study at any time without giving a reason. If you decide to leave the study, all the information provided by or about you will be removed from the study. Your decision about joining the study will not affect other treatment you are receiving from your therapist.

Research results will be shared with you if desired (see consent form).

If you have questions or concerns or need more information about this project, please contact Dr. Cindy Hardy at 960-5814. If you have complaints about this project, please contact UNBC's Vice President of Research at 960-5820.

Attached are two copies of the consent form. Please complete the forms then return one copy to the researcher and keep the other copy along with this letter for your records.

Client Consent Form
Prince George Attachment Project

Please complete this form to indicate your understanding of the project and to indicate your decision regarding consenting to participate.

Do you understand that you have been asked to participate in a research study?	YES	NO
Have you read and received a copy of the attached information sheet?	YES	NO
Do you understand that your play sessions with your child and your therapy sessions with your therapist will be videotaped and used for research?	YES	NO
Do you understand that the research reports based on the information you submit will respect your privacy and maintain your anonymity?	YES	NO
Do you understand the risks and benefits of participating in this study?	YES	NO
If you chose to refuse or withdraw, you do not have to give a reason and you will continue to receive the usual services from your therapist. If you withdraw, all information provided by or about you will be removed from the study. Do you understand that you are free to refuse to participate and/or withdraw at any time without consequence?	YES	NO
Has the issue of confidentiality been explained to you? Do you understand who will have access to the information you provide?	YES	NO

This study was explained to me by _____.
Check one of the following to indicate your decision regarding participation:
_____I agree to fully participate. I agree to contribute information to the study and my therapist has my permission to share information about me with the researchers.
_____I agree to partially participate in this study. I will not contribute information to the study but my therapist has my permission to share information about me with the researchers.
_____I do not agree to participate in this study. My therapist does not have my permission to share information about me with the researchers.

_____ I wish to receive a written report of the research findings. My therapist will provide the summary to me when it becomes available.

_____ _____ _____.
Name of Parent (printed) Date Signature of Parent

_____ _____ _____.
Name of Guardian (printed) Date Signature of Guardian

_____.
Name of Witness (printed) Date Signature of Witness

I believe the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____.
Name of Researcher (printed) Date Signature of Researcher

Appendix B

Academic and Work Experience

Please describe your academic and work experiences that are directly relevant to delivery of MIG and to clients.

1. What level of post-secondary education have you attained and in which discipline/s?

2. Describe the theoretical training you experienced during your education (i.e., psychoanalysis; attachment theory)?

3. During training, what forms of supervision did you receive when learning how to work with clients?

4. Have you had any additional training leading to certification since completing your degree/s? If yes, describe the training and list the certificates achieved.

5. What additional courses or workshops have you completed since your degree/s?

6. What work experiences have you had that are directly related to working with parents and young children?

7. What skills helped you do that work?

8. What skills and insights have you gained from these work experiences that might help you administer MIG?

9. Additional comments?

Disrupted Communication Rating Scale

Client ID: _____ Date: _____

This questionnaire will be completed by researcher after team meeting where videotaped parent-child sessions are observed.

1 = No need for intervention (not disrupted - 1,2, and 3 rating on AMBIANCE)
2 = May benefit from intervention (perhaps disrupted - 4 and 5 rating on AMBIANCE)
3 = High need (definitely disrupted – 6 and 7 rating on AMBIANCE)

1. _____Prior to the intervention, what degree of disrupted communication was displayed?
2. _____After the last treatment session, what degree of disrupted communication was displayed?

What is the team's rationale for rating this client as they did?

_____

_____

_____

_____

_____

Pre-treatment Client Questionnaire

Please ask your client these questions in your first session.

1. What do you hope to get out of this treatment?

2. What do you want to see change?

3. How motivated are you to make the changes we have been talking about?
   1 = not at all motivated; 5 = very motivated

4. How would you know if the treatment is working?

5. Do you think that your parenting behaviours influence your child's behaviour? Describe.

6. How willing are you to make changes in your parenting behaviour?
   1= not all motivated; 5 = very motivated

Pre-treatment Clinician Questionnaire

Clinician: _____

Client ID: _____ Date: _____

After you have completed the intake interview, parent-child play session with rating of disrupted communication, Adult Attachment Interview (optional), and Working Model of Child Interview (optional), please complete the following questions.

1. _____ How would you rate the therapeutic alliance you have with this client?

1 = Poor – lack of trust is a major barrier to treatment
2 = Fair – trust is sufficient enough to start treatment
3 = Good – have started to build a relationship
4 = Strong – relationship will withstand some challenges
5 = Very Strong – relationship will support change

2. Using the stages of change descriptions (see attached sheet) what stage is your client currently in? Check the box that best applies.

- ❑ Precontemplation
- ❑ Contemplation
- ❑ Preparation
- ❑ Action
- ❑ Maintenance
- ❑ (Relapse)

Clinician's Journal

One way to understand the utility of the MIG is by gaining an understanding of your experiences administering the MIG. After each session, I would like you to make some notes about the session including notes regarding client responses. You may want to think about the processes that take place during the treatment and your own thoughts and feelings, such as:

1. How did the session go today?
2. How did the client respond to me? Does he/she want to participate? If there was not a positive response to the session or myself, what could be causing this?
3. Was there any difficulty in our communication with each other?
4. Do we have a good rapport? Does the client trust me?
5. Am I seeing improvement in the client's behaviours with child?
6. How did I respond to my client?
7. Was I sensitive to my client's needs, fears, experiences, opinions etc?
8. Do I think that my client will have a positive response to the treatment? Why or why not?
9. How did I feel emotionally and physically after the session?
10. Do I notice that there are any skills of yours that are weak or missing that may contribute to the success or lack of success of this treatment?
11. Are there any changes that I need to make for the next session to obtain a more positive result?

Client Rating of Improvement Scale

Date: _____

This questionnaire will be completed by client after last session.

1 = Much worse
2 = Somewhat worse
3 = No improvement
4 = Somewhat improved
5 = Much improved

1. _____ After treatment, how would you rate your level of improvement regarding changing parental behaviours?

Why did you make the ratings that you did?

_____
_____
_____
_____
_____
_____
_____

Post-treatment Client Questionnaire

Please complete the following questions to the best of your ability.

1. Do you think that the clinician did a good job of administering this treatment with you? Explain your answer.

2. Describe your thoughts and feelings about the clinician who worked with you on the treatment?

3. Describe anything that you did not like about the clinician or the way that they administered the treatment?

4. Describe how you found the homework assignments?

5. Describe any changes you noticed in your child's behaviour?

6. When did you first start noticing these changes?

7. Do you think that the treatment worked for you and your family? If yes, why? If not, why not?

Clinical Rating of Improvement Scale

Clinician: _____

Client ID:_____ Date: _____

This questionnaire will be completed by clinician after last session.

1 = Much worse
2 = Somewhat worse
3 = No improvement
4 = Somewhat improved
5 = Much improved

1. _____After treatment, how well did your client improve in changing parental behaviours?

What is your rationale for rating the client's improvements as you did?

_____

_____

_____

_____

_____

_____

_____

_____

Supervisor Interview Questions

1. Overall, how did you find the experience of supervising the clinical team in the use of MIG?
2. What challenges did you face supervising the clinical team?
3. Did you feel that the audiconference sessions were beneficial? Was the time allocated to audiconference sessions used adequately?
4. What does a successful treatment mean to you? What does a successful treatment look like?
5. In what ways was this treatment a success and/or a failure? What went well and didn't go well?
6. Generally, what characteristics does a clinician need to competently administer attachment relevant interventions?
7. How prepared did you think that the team was in using MIG?
8. In general, how does a clinician's academic and work experience influence the outcome of MIG or other attachment relevant interventions?
9. In what ways was this or was this not an appropriate teaching case?
10. What type of person responds well to MIG or other attachment relevant interventions?
11. What situational factors may have influenced the outcome of this case?
12. Having supervised other groups learning MIG, how did our group differ from others and how were we the same?
13. What challenges may smaller communities face when trying to implement MIG or other attachment relevant interventions?
14. Is there anything else you would like to add about MIG, the team, the sessions, or the treatment as a whole?

Treating Clinician Interview Questions

1. How did you find this whole experience, from pre-treatment to post-treatment?
2. How has your academic and work experiences influenced your ability to administer MIG? From your work experiences, what skills did you apply to MIG? Overall, what are the skills you need to work on?
3. What personal reactions to the client or her response to treatment did you become aware of? How might this have affected treatment?
4. In what ways do you think that the treatment was successful? What does successful mean to you, to the client?
5. Overall, what factors do you think contributed to the outcome we observed? What individual client factors? What clinician factors? What dyadic or relationship factors?
6. What were the warning signs that MIG was not working as intended?
7. In your opinion, what type of parent – child dyads will respond well to the MIG? What type of parent – child dyad will not respond well to MIG? What are key client characteristics to look for when recommending MIG to clients?
8. What did you think of the audiconference sessions with Sonya?
9. In what ways did you feel supported by Sonya? How did you feel about the feedback she provided?
10. Use as probe to question 10,11 - In what ways could your learning experience have been made better or easier?
11. What things did you discover through this learning process that could make MIG more successful (e.g., training, number of sessions)?
12. Given your experience learning MIG, what do you think are the factors or issues that other northern or rural communities need to considered when learning to implement MIG?
13. What else would you would like to add about MIG, the supervision, the sessions, or the treatment as a whole?

Observing Interview Questions

1. How did you find this whole experience, from pre-treatment to post-treatment?
2. How has your academic and work experiences enhanced your understanding of MIG?
3. What personal reactions to the client or to her response to treatment did you become aware of? (In what ways was your attachment system activated?)
4. What does a successful treatment mean to you, to the client? In what ways do you think that the treatment was successful?
5. Overall, what factors do you think contributed to the outcome we observed? More specifically, what individual client factors? What clinician factors? What dyadic or relationship factors?
6. How did you feel about the audioconference supervision that you received throughout this process?
7. In what ways do you think that Chantelle was supported?
8. In what ways could your learning experience have been made better or easier?
9. What things did you discover through this learning process that could make MIG more successful (e.g., training, number of sessions)?
10. How did you feel about the partner role and do you have any suggestions for changing it?
11. Given your experience learning MIG, what do you thing are the factors or issues that other northern or rural communities need to consider when learning to implement MIG?
12. What else would you like to add?